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26 April 2008

C+D Awards: are you on the shortlist?

Find out on page 18

A step ahead in cracked heel repair

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A pharmacy guide to the first NICE guideline on Irritable Bowel Syndrome (IBS)

The National Institute for Health and Clinical Excellence (NICE) has issued guidelines for the first time on the diagnosis and management of Irritable Bowel Syndrome (IBS) – a "*chronic, relapsing and often life-long disorder*" – which may require pharmacological therapy for symptom relief. IBS affects around 10-20% of the population[1] and it is therefore essential that pharmacists are well equipped to advise customers on this common bowel problem.

Pharmacists have a key role to play in the treatment of IBS

The new NICE guideline states that people with IBS should be given information that explains the importance of self-help in effectively managing their IBS once they have been diagnosed.[1] This should include information on general lifestyle, physical activity, diet and symptom-targeted medication – often available over-the-counter.

NICE also encourages IBS sufferers to seek advice from pharmacists, promoting the ongoing management of this condition.

Shailesh Amin, a pharmacist from Croydon:

"It is encouraging to see NICE taking IBS seriously and confirming the role of pharmacists in the management of this common and life-long debilitating condition. IBS symptoms such as constipation and abdominal pain are common complaints from customers and once IBS is diagnosed pharmacists are ideally positioned to provide treatment and support."

Getting diagnosed

According to NICE, patients experiencing abdominal pain/discomfort, bloating, or a change in bowel habit, for at least six months should be referred to a GP to be assessed for IBS. For a positive diagnosis of IBS to be made, the person must complain of abdominal pain or discomfort, which is either relieved by going to the toilet, or associated with altered bowel frequency or altered stool form.[1] This must be accompanied by at least two of the following four symptoms:

- altered stool passage
- abdominal bloating, distension, tension or hardness
- symptoms made worse by eating
- passage of mucus.

To make it easier for IBS sufferers to be diagnosed and recognise their symptoms, an 'IBS Symptoms Checklist' (a discreet handbag-sized resource) is available to request or download from popular patient website *www.ibs-relief.co.uk*. It can be used by patients to help initiate a conversation about IBS diagnosis with a healthcare professional, such as a pharmacist.

Communication resource

Visit *www.bowel-health.co.uk* for a practical guide on how to improve communication and aid dialogue when discussing IBS and other common bowel problems with customers.

Buscopan® IBS Relief (hyoscine butylbromide 10 mg)

- Buscopan® IBS Relief is clinically proven to provide effective relief from abdominal pain caused by cramps and spasms associated with medically confirmed Irritable Bowel Syndrome (IBS)
- The active ingredient in Buscopan® IBS Relief is derived from natural hyoscine extracted from the Duboisia plant
- Hyoscine has a relaxing antispasmodic effect which works directly on the cramping muscle of the bowel to ease the pain and discomfort of abdominal cramps and spasms
- Visit *www.buscopan.co.uk* for more information on IBS and Buscopan® IBS Relief – the No.1 selling brand in the antispasmodic category[2]

IBS Management – An overview of NICE's recommendations

(modify according to symptoms and treatment response)

Drug Therapy

1st line

Antispasmodics

Recommended as a first-line treatment for abdominal pain and discomfort, to be taken as required[1]

Laxatives

Should be considered for the treatment of constipation in people with IBS, but they should be actively discouraged from taking lactulose[1]

Antimotility Agents

Loperamide – first-line treatment for IBS related diarrhoea[1]

2nd line

Tricyclic antidepressants (or SSRIs)

Lifestyle: Diet and Physical Activity

Assess Diet

- Reduce fibre intake, particularly insoluble fibre
- Increase soluble fibre intake such as oats and linseeds
- Consider dietician referral

Assess level of physical activity

- Encourage increased levels of activity

Patient information resources

- Dietary, lifestyle and self help advice

References

1. Irritable bowel syndrome: NICE guideline, NICE clinical guideline 61, February 2008
2. IRI Data Top IBS Brands MAT Value % Share; 52 w/e 22 March '08

Buscopan IBS Relief: *Active ingredient:* Tablet, containing hyoscine butylbromide 10mg. *Indication:* Relief of gastro-intestinal tract spasm associated with medically confirmed irritable bowel syndrome. *Dose:* adults and children over 12 years only: initially 1 tablet three times daily, increasing if necessary to 2 tablets four times a day. *Contra-indications:* myasthenia gravis, acute narrow angle glaucoma, known hypersensitivity to any ingredient. *Warnings and precautions:* conditions characterised by tachycardia, susceptible to intestinal or urinary outlet obstruction, patients should seek medical advice if they develop a painful red eye with loss of vision whilst or after taking Buscopan IBS Relief. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take Buscopan IBS Relief since the tablet coat contains sucrose. Advise patients to consult their doctor before taking IBS Relief if: age over 40 years and some time since the last attack of IBS or the symptoms are different, recent rectal bleeding; severe constipation; nausea or vomiting; loss of appetite or weight, difficulty or pain passing urine; fever; recent travel abroad. Advise patients to consult their doctor if they develop new symptoms, or if symptoms worsen, or if they do not improve after 2 weeks of treatment. *Interactions.* Co-administration with a dopamine antagonist may diminish the effect of both medicines. *Undesirable effects:* dry mouth, tachycardia, hypersensitivity, skin reactions. Rare: urinary retention; dyshidrosis; isolated cases of anaphylaxis with episodes of dyspnoea and shock. *Pack size and retail price:* 20 tablets £4.39 PL 00015/0253 *Legal category:* GSL *Product Licence Holder:* Boehringer Ingelheim Ltd., Ellesfield Avenue, Bracknell, Berkshire RG12 8YS. For full information please see Summary of Product Characteristics. Prepared in August 2006.

Chemist + Druggist
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Comment from the Editor

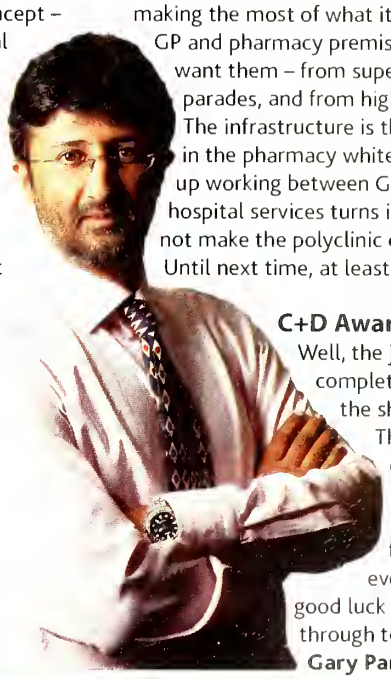
Flared trousers, platform shoes and Olympic-sized sideburns – no matter how bad the original idea, it seems inevitable that at some point it's recycled and championed as the next big thing. Which brings me to polyclinics.

We've had super surgeries, one-stop primary care centres, NHS Lift and walk-in centres – all sharing a collective ethos of bringing services under one roof to improve patient care. So the idea of polyclinics, borne out of Lord Ara Darzi's latest review of NHS services, is nothing new.

In principle, it's hard to argue with the concept – key services co-located in the heart of a local community. In theory, at least, it should provide patients with easy access to specialist services in state-of-the-art premises, with the added bonus of extended opening hours. A New Labour panacea, if you will.

But as our news feature (page 14) reveals, the polyclinic model of service is not one that is embraced by GPs or pharmacists. For our medical colleagues, perhaps it's the thought that private companies could provide competing GP services through APMS contracts. For pharmacists, it's the recurring problem of how a large number of GPs co-located in a single unit with an onsite pharmacy will affect the surrounding network of pharmacies.

There is a danger here that we could be seen as protectionists and afraid of embracing change – but that would be unfair. Rather than looking to invest significant sums in new premises, should the NHS not be making the most of what it already has – some 30,000 GP and pharmacy premises located where patients want them – from supermarkets to secondary parades, and from high streets to rural villages. The infrastructure is there and, if the aspiration in the pharmacy white paper for more joined up working between GPs, pharmacists and hospital services turns into reality, will this not make the polyclinic debate redundant? Until next time, at least.



C+D Awards 2008

Well, the judging process is now complete and this week we reveal the short-listed entries (page 18). The standard has been excellent and the 39 who made it through to the final stage have set the bar high for next year. So thanks to everyone who entered and good luck to those that made it through to the final cut.

Gary Paragpuri, Editor

Contents

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Polyclinic call for calm backfires

Fresh attacks on all-in-one healthcare centres follow NHS Confederation report

Rob Finch

An attempt by NHS chiefs to take the heat out of the debate on polyclinics backfired this week.

Pharmacists, GPs and the Conservative Party all launched fresh attacks on proposals for the all-in-one healthcare centres, after the NHS Confederation set out to "calm" the debate by issuing an appraisal of how they might provide integrated care, better access to services and better value.

Nigel Edwards, director of policy for the Confederation, said he had been "genuinely surprised" at the level of "knee-jerk" opposition to the polyclinic model.

But the British Medical Association was "against the headlong rush into polyclinics", said Dr Laurence Buckman, chairman of the BMA GPs' Committee.

And Stephen Fishwick, head of external relations at the NPA, said: "GP leaders were right to ask PCTs to approach this with caution.

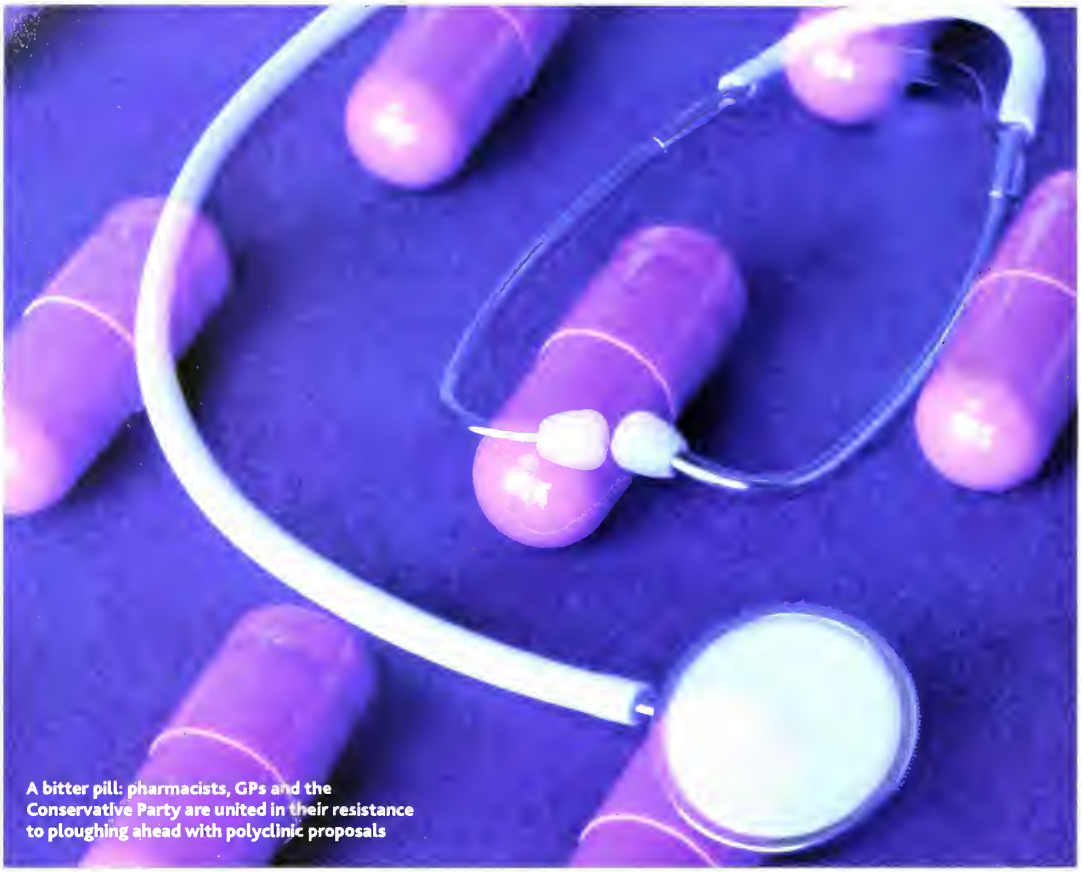
"We think the law of unintended consequences could apply – it could make some neighbourhoods health deserts with no pharmacy or GPs in the areas people live, work or shop."

The NPA has written to the Confederation to ask for talks on how the scheme might impact on pharmacy.

Conservative leader David Cameron weighed in on the debate by saying that polyclinics should not be "imposed" on local communities without public and doctors' support.

They could lead to the closure of one in five GP surgeries, he added: "It is quite wrong."

For more pharmacy perspective on polyclinics turn to page 14



A bitter pill: pharmacists, GPs and the Conservative Party are united in their resistance to ploughing ahead with polyclinic proposals

Fraud office continues case against Goldshield

The government's Serious Fraud Office (SFO) has decided to continue a prosecution against the drug company Goldshield over alleged price fixing involving generic medicines.

Despite a House of Lords ruling last month that price-fixing does not amount to conspiracy to defraud, the SFO has decided to defend and continue its prosecution case.

A preliminary hearing has been set for April 28 at Southwark Crown Court.

Goldshield chairman Keith Hellawell said the company was "clearly disappointed". He said: "We will continue to defend our position rigorously."

Goldshield first announced that it was being investigated by the SFO in April 2002.

The company has separately reached settlements in civil cases with health services in England, Scotland and Ireland, without admission of liability. **KO**

'Reassessment of error referrals needed'

A "radical examination" of how the RPSGB deals with dispensing errors is needed, before power is passed to a separate regulatory body.

This was the view of the Pharmacy Law and Ethics Association (PLEA), in response to the RPSGB's consultation on criteria for one-off dispensing errors not to be referred to its Investigating Committee.

PLEA chairman Joy Wingfield said it was time to reassess "the whole rationale for enforcement of disciplinary norms in community pharmacy".

Particular areas to address included:

- discrepancies between the ways hospital and community pharmacy errors were dealt with
- the need to take into account a pharmacist's working environment and who their employers are in considering accountability for errors
- the "unjust" practice of maintaining warnings on an individual's history for an indefinite period.

RPSGB director of fitness to practise and legal affairs Mandie Lavin stressed that the Society dealt with "all complaints sent to it from any sector of pharmacy", and that all cases were considered "in the context of the practice setting in which the pharmacist is working".

Expiry of warnings was likely to be re-examined in establishing arrangements for the proposed future General Pharmaceutical Council, Ms Lavin said.

Ms Lavin added that the RPSGB Council would be considering the outcome of the consultation at a future meeting. **KO**

PCT puts £500k cat M savings into services

Drugs bill surplus ring-fenced to develop community pharmacy schemes

Jennifer Richardson

A primary care trust is ploughing thousands of pounds-worth of savings resulting from category M price reductions back into pharmacy services.

Heart of Birmingham Teaching PCT (HoBtPCT) identified a £1 million drugs bill surplus as a result of changes to the generic medicines tariff.

The PCT's professional executive committee (PEC) has agreed with its finance director to ring-fence half of that – £500,000 – for the development of services in community pharmacies, PEC pharmacist Murtaza Master told C+D.

The PEC has also secured an additional £15,000 to purchase external consultation on potential enhanced pharmacy services, Mr Master said.

A HoBtPCT spokesperson said it would use the allocated funding to apply the principles of the recent pharmacy white paper.

"We will of course consult with community pharmacists and other professionals to make the best possible use of the funds and skills available to us for the benefit of our patients," he added.

Mr Master said that, if used properly, the money was a "huge opportunity" for community pharmacy to prove its worth.

Pharmacist Dilip Patel, of Birmingham's Mirage Pharmacy, said he was "more than pleased" with the "excellent news". And PSNC head of finance Mike Dent agreed the arrangement was "absolutely brilliant".

Using category M clawbacks to fund pharmacy services was not an argument the contract negotiator could use centrally, he emphasised: "The Department [of Health] would argue that the money's come out because pharmacists have been paid too much, and they don't recognise ring-fencing."

But the arrangement could potentially be repeated in other PCTs. Mr Dent said: "At a local level, it's a great argument for LPCs to use... to keep money in community pharmacy."

Murtaza Master: money is a "huge opportunity" for community pharmacy to prove its worth

Multiples' funding warning

Two of the UK's largest pharmacy chains have issued fresh warnings to the government about funding uncertainty that is stifling investment in patient services.

Both The Co-operative Pharmacy and Lloydspharmacy said further reductions in generics purchase profits would restrict their ability to develop services to meet the aspirations of the pharmacy white paper and address NHS health priorities.

Co-operative Pharmacy managing director John Nuttall said category M clawbacks had resulted in an "unexpected, additional financial burden" of £11.2 million in 2007.

Mr Nuttall said: "I'm very concerned that contract funding by the Department of Health is inadequate, and that repeated removal of money for category M reimbursement is hampering our ability to invest for the future of pharmacy services.

"If this continues, year-on-year, all pharmacies, not just us, will face a real struggle."

A Lloydspharmacy spokesperson declined to reveal the exact financial impact of reimbursement reductions on the company, but agreed: "If there are further draconian reductions it could threaten our ability to develop services." **JR**

'Long journey' ahead for white paper

The pharmacy white paper is unlikely to provide a quick-fix for the profession, representatives have said.

The Independent Pharmacy Federation pledged to work with the DH "to speed implementation" of the vision of the white paper.

The group has identified key areas it believed could be taken forwards relatively quickly, including the minor ailments scheme and long-term conditions management.

Such promised additional services in the paper could boost pharmacy's role and profits. But AAH group managing director Mark James said it would be a "long journey, because there's going to be a need for a lot of consultations, a lot of proposals, and these are going to take months, even years, to complete". **ZS**

News in brief

SG tackles violence

The Scottish Government has extended its campaign to tackle violence against NHS staff to include community pharmacists. Pharmacies should receive posters and leaflets by early May.

Crystal meth sentence

A would-be crystal meth manufacturer has been sentenced to four years in prison. Stuart Gyger set up a factory and was caught with chemicals that would have produced £50,000-worth of drugs. Police confirmed the chemicals were not sourced from UK pharmacies.

New NPA guides

Resources for the supply of anticoagulant therapy and oral anti-cancer medicines can be downloaded at www.npa.co.uk. They comprise template SOPs and guidance notes, and comply with NPSA recommendations.

Diabetes dilemma

The government will fail to deliver on diabetes service standards it set itself five years ago, if it does not refocus NHS efforts. Charity Diabetes UK said half-way through 2003's 10-year National Service Framework, services were patchy and putting 1.9 million at risk.

Online repeats service

A service enabling patients of independent pharmacies to order repeat prescriptions online has been launched. myrepeats.com is free to patients, but pharmacies pay 20p per script after a £50 sign-up fee.

C+D Awards holiday winner

Roy Gillman, of Sheffield Pharmacy in Hertford, is the lucky winner of a holiday of a lifetime worth £3,500. Mr Gillman was chosen at random from entrants to the inaugural C+D Awards. See p18 for the newly-published shortlist.

Dispensary TALK

Do you think prescription directing is happening in your area?

"No, without doubt. In this area everything is above board with the GPs."
Geoff Ray, Total Health Pharmacy, Norfolk

"Prescription directing definitely happens in our area. Patients are not given the choice of which chemist they would like to use – GP administrators are making the decisions."
Ashok Mehta, Davina Pharmacy, Tyldesley, Manchester

WEB VERDICT:

Yes 47%
No 32%
Possibly 21%

Armchair view: They wouldn't, would they? They have, haven't they? Yes, some surgeries are directing prescriptions and deserve a big ethical slap on the theoretical wrist, you say.

Next week: Could polyclinics be the future of pharmacy? Vote at www.chemistanddruggist.co.uk

More purchasing power for GPs, says Cameron

Pharmacy chiefs flag up potential conflict of interest

Rob Finch

David Cameron wants to improve practice-based commissioning by putting yet more purchasing power into the hands of GPs.

But pharmacy chiefs rejected the Conservative leader's plans for GPs to hold budgets for purchasing care on behalf of their patients.

Speaking at the King's Fund this week, Mr Cameron told senior health figures that errors in the setting up of practice-based commissioning meant "we've ended up with neither a GP-led service nor an efficient central bureaucracy".

He said: "GPs should be responsible for providing the care patients need or commissioning it from other providers... or a mixture of the two.

"There is a good economic rationale for this. Budget holders are a central guarantee of value for money, ensuring that the money follows the patient and ensures it is spent on frontline care rather than central bureaucracy."

But NPA head of external relations Stephen Fishwick said: "There is a conflict of interest in being both the commissioning budget-holder for services and a provider of services."

And Alastair Buxton, head of NHS services at PSNC, said the speech sounded like "an attempt to win GP votes". He added: "It's probably best to get practice-based commissioning working properly before tinkering further."

David Cameron: more power to the GP

Conflicts of interest arising from GPs commissioning and providing work would be resolved by PCT oversight, Mr Cameron said.

MP visits go west

MP Bruce George with Julie Morran at Rowlands Pharmacy

The Building Bridges campaign hit the west this week as MPs visited pharmacies in Penzance, Worcester and Walsall.

Liberal Democrat MP Andrew George, for West Cornwall and the Isles of Scilly, cut the ribbon on the new Day Lewis flagship branch, Peasgoods Pharmacy in Penzance. He said: "It is reassuring and very welcome to see real investment and confidence in the future of town centre shops and services."

In Worcester, Labour MP Michael Foster impressed Sheena Bescopy of Giles Pharmacy with his knowledge of the issues affecting pharmacy. Mr Foster brought up the recent white paper during a discussion on stop smoking services, and advised Ms Bescopy to write to him about category M.

Meanwhile, at a Rowlands Pharmacy, regular customer Bruce George, Labour MP for Walsall South, dropped in to find out more about medicines use reviews.

Mr George had expressed surprise at the range of services on offer, said branch manager Julie Morran, and had been particularly pleased to be able to take advantage of the pharmacy's home delivery service in recent weeks. **RF**

No 'rebadged' RPSGB please

An independent committee should be set up to guide the creation of a new professional body, specialist pharmacy groups have stressed.

More than 30 pharmacy organisations agreed the RPSGB should set up and host the committee, but that it should comprise grassroots pharmacists and external experts in areas such as finance, HR and marketing.

The decision was made at a meeting of the 'Waterloo Group' on April 14 to discuss the Clarke Inquiry's proposals.

Group members, including AIMp, CCA and the British Pharmaceutical Students' Association, emphasised a new professional body must not be a "rebadged RPSGB". More at www.chemistanddruggist.co.uk. **KO**

Cast your vote

Who do you want to see on the RPSGB Council? Three places are up for grabs in the 2008 election, which closes on May 9, but you can cast your vote online in C+D's unofficial election barometer at www.chemistanddruggist.co.uk

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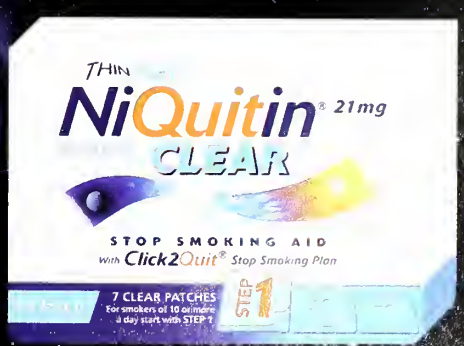
Ask your Pharmacist first



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Convention bytes

MAS moans

Pharmacists in Scotland are facing problems with the national minor ailments service, according to Len McAllister, chairman of support group AlbaPharm. Despite positive feedback from patients and health professionals, issues remain over pay, patient registration and transmitting prescriptions to health boards.

Commissioning boost

Proposed local commissioning groups in Northern Ireland look set to boost opportunities for pharmacists. The groups would include pharmacist members and look at commissioning services locally, and were "encouraging", said Sheelin McKeagney of McKeagney Pharmacy Practices.

More AAH education

AAH's educational offering has been boosted by two additions this week: an NVQ in retail operations and a foundation degree in retail management.

Targeted MUR benefits

The patient benefits of targeted MURs have been demonstrated in a trial run by Hampshire & IoW LPC. Ninety-one per cent of patients said they understood more about their medicines after an intervention on improving asthma inhaler technique.

Customer care

Pharmacists need to look at their businesses with a customer's eye to realise why they have lost 2 per cent share to multiple grocers in two years. Trevor Gore, training and development manager at Reckitt Benckiser, said customers want clutter-free stores with clear category facings and prices, where staff provide a knowledgeable and friendly atmosphere.

GPs: friend or foe?

GPs recognise pharmacists' proven value for money in medicines management, but are sceptical about their ability to deal with complex clinical problems, according to a Devon GP. But Dr David Jenner, NHS Alliance PBC lead, added there were areas for collaboration between the professions.

For more on these stories, visit www.chemistanddruggist.co.uk/news

Profit increases are 'there for the taking'

AAH delegates in South Africa hear how tax planning could save cash

Zoe Smeaton

There are opportunities for pharmacists to boost their businesses financially despite recent cashflow problems, AAH convention delegates in Cape Town heard.

Umesh Modi, a specialist financial advisor to pharmacy businesses, told C+D: "If everything in the white paper comes to fruition... there are huge opportunities to provide enhanced services and potentially make further good profits."

Mr Modi had many financial tips for contractors at last weekend's AAH convention in South Africa. These included putting aside money for future category M clawbacks, trying to claim tax relief on the clawbacks, proactively taking up MURs and doing VAT return forms monthly, rather than quarterly, to improve cashflow.

"A lot of pharmacists are simply not spending the time to consider tax planning which could save them a significant amount of money," he said.

But pharmacists would need to adapt their working practices to embrace new clinical roles, in order to boost profits in the future, delegates were also told.

Arthur Daines, non-executive director of pharmacy development group CamRx, said pharmacists would find the change "painful" but added that their eventual clinical role could be more rewarding. "They are going to be doing what they originally trained to do," he said.

AAH group managing director Mark James identified the new opportunities as a key theme emerging from the wholesaler's event. He said: "The financial climate for pharmacy is getting tougher – is tough – but there are still opportunities out there if you want to grasp them."

'Don't be apathetic – have a say on your leadership body'

Pharmacists must not underestimate the importance of their future leadership body, an NHS chief has warned.

National Prescribing Centre chief executive Clive Jackson told C+D that pharmacists must have their say on what that body should look like. Following the Clarke Inquiry, which considered how the professional body should be formed, he said: "Apathy at this stage is really the worst thing we could have."

One issue up for discussion is potential fees for the leadership body and the separate regulator that will arise from the split of the RPSGB's dual role.

Mr Jackson said at last weekend's AAH convention: "We need to be considering what it is we're happy to pay to be effectively regulated and appropriately guided as a profession."

Mr Jackson favoured a faculty model for the body, bringing together the whole of Great Britain. Different faculties could accommodate different groups within pharmacy, and an umbrella structure would allow people from each group to come together as a leadership group. **ZS**

Hampshire & IoW LPC chief Mike Holden took part in a delegates' polo match in Cape Town. For more AAH Convention news and pictures see page 42 and www.chemistanddruggist.co.uk/news

'Get to grips with responsible pharmacist now'

Pharmacists have been advised to get to grips with the concept of the responsible pharmacist before its introduction.

NPA chief pharmacist Colette McCreedy told AAH Convention delegates that both employees and employers needed to prepare for the challenge of proposed changes to supervision requirements.

Responsible pharmacists in charge of the delivery of pharmacy services from individual premises could be absent from those premises for up to three hours a day, she said.

SOPs would be integral to managing this and a review would be timely, she added. In addition, employers would be likely to prefer regular locums familiar with a premises' procedures.

There was a need to "tread carefully" in developing the model, Ms McCreedy warned. "We have been selling the concept of easy access to a trained healthcare professional for a long time as a USP for community pharmacy. We need to tread carefully and slowly in developing the responsible pharmacist concept." **PG**

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Polyclinics: the pharmacy perspective

A new report has fired up opinion over one-stop healthcare centres. GPs have made their feelings clear, but what does pharmacy think? **Rob Finch** finds out

The mention of polyclinics in the context of the British National Health Service raised howls of protest this week.

Despite the publication of a report by the NHS Confederation that called for "calm" and "common sense" in the polyclinic debate, GPs have declared that the model will undermine traditional general practice and thus destabilise NHS primary care as we know it.

In addition, the Conservatives have slammed the proposals, claiming they could lead to the closure of one in five GP surgeries.

The government conversely argues that healthcare centres providing primary care as well as some social care, diagnostics and outpatient services all in one place will create more choice for patients and greater access to more varied care.

But where does pharmacy stand on the issue?

Stephen Fishwick, head of external relations at the NPA, said GPs were right to sound a warning, and cautioned against the apparent "hurried thinking" by ministers.

Mr Fishwick claimed the only official plans – set out by (the then) Professor Darzi in his Healthcare for London review of the capital's NHS – fail to address pharmacy head-on.

"It doesn't really give the issue the coverage that it deserves," he said.

"What we're not wanting to say is that the model is flawed in all cases. It's just that implementation must be extremely carefully carried out to avoid damaging existing community-based networks.

"If all your local GPs up sticks and move away, that'll impact on pharmacy."

And Mr Fishwick warned that the proposed new buildings might mean pharmacists would be taking a big risk investing in new premises or services, as spelled out by the pharmacy white paper.

David Kent, secretary of Camden & Islington LPC, was less equivocal. Camden PCT has reportedly decided to have five polyclinics and Mr Kent said: "This LPC is absolutely 100 per cent violently against them.

"It's disastrous for the little guy. For every polyclinic that opens we calculate we'll lose five pharmacies, as every single polyclinic will have an on-site pharmacy.

"If we assume that 70 to 80 per cent of prescriptions are dispensed close to where they're written or electronically transmitted, then it's likely that they'll go to the on-site pharmacy."

Mr Kent added: "The NHS and patients would be best served if Darzi's pen was confiscated and they gave him back his scalpel."

Elsewhere in London, Dinesh Patel, secretary of Merton, Sutton & Wandsworth LPC, is annoyed that the polyclinics programme has focused on GPs running primary care.

He said: "The LPC is not particularly happy that the polyclinics will be GP-led – where did that come from? The people who can't run their front desks are going to be running these polyclinics. It's totally dominated by doctors and, as with practice-based commissioning, they won't let anyone else in."

> "The NHS would be best served if Darzi's pen was confiscated"

But in Liverpool PCT, plans for a federated polyclinic model were praised by the NHS Confederation publication. And Liverpool LPC's secretary Jeremy Clitherow is more sanguine than some of his London colleagues.

"It's a curate's egg – good in parts. The idea is excellent and well supported and would enable the best use of scarce resources and a big investment on one site rather than spread out over the whole area."

But he warned that centralising services could add to the inverse care law by making access harder for the elderly and chronically ill, who could have to travel further for their treatment.

In Devon, where the polyclinic in Tiverton Hospital has been cited by Lord Darzi, the LPC's strategic business officer Jonathan Kerr believes the rhetoric has not kept up with the policy direction, which he called "a wonderful opportunity".

"Darzi seems to have moved away from the idea of polyclinics towards the idea of integrated services," he said, referring to the protocol-driven integrated care pathways gaining credence for dealing cost-effectively with many conditions.

"The PCT is actively looking to commission services from pharmacists and we would support that. From an LPC, we would welcome any way for people to access pharmacy services.

And Michael Levitan, secretary of the Middlesex Group of LPCs, agreed that – if handled correctly – polyclinics could be good for pharmacy.

"I think the hub and spoke model is ideal for pharmacy – it's one model where you could keep a network of pharmacies in the community, providing pharmacy services of the same or different kind as in the polyclinic."

He added that the most appropriate way for the scheme to work would be to have a network of local pharmacies that own and run the pharmacy in the polyclinic. In Finchley, north London, exactly that model has been working at a health authority-owned premises for the last 25 years.

But getting such schemes agreed is far from easy, and Mr Levitan believes there is a lot of work to be done.

"The message to PCTs and other stakeholders is to work with your LPCs and existing pharmacies, so that rather than being seen as a threat it's seen as a way to extend services."

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The patient whisperers

Talking to patients is often like talking to children or dogs. Keep it simple, be honest but firm, and remain consistent. Trouble is, the average three minute consultation often isn't long enough to bring them round to my way of thinking.

Hence the white paper announced some significant government research into non-compliance in an effort to cut the £100m+ of medicines wasted every year. I could save them the bother. The answer is that whatever you say to some people, they simply don't get it.

Some concepts are easy for everyone to understand, like, "don't take aspirin while you're on warfarin or you'll bleed to death". Or: "Use a condom while you're on these antibiotics or else you'll get pregnant." But others, like, "we can't sell you two packs of paracetamol because somebody might use them to commit suicide" can be notoriously difficult to get across.

The recent announcement preventing the sale of certain OTC medicines to children under two years old has proved to be one of the trickier messages to communicate. What people can't seem to get beyond is the argument that: "I've always given that medicine to my children when they've been under two and they're all fine. How can it have been safe last week and not this week?"

Having kindly given one lady much more than her allotted three minutes to explain why she shouldn't dose her baby up with Medised, she bought some anyway "for my older children". And then she was heard to mutter under her breath as she walked out, "I'm going to give it to him anyway, see if I care". Of course there was no time to make a note of this conversation to use as evidence when she takes me to court for failing to prevent her from giving it to her baby.

Jean and Margaret are finding this issue more difficult than most of the others they have dealt with so well in the past. For example, kaolin and morphine is now kept under the counter and they can spot a potential abuser a mile off. And they have been so thoroughly briefed about the pseudoephedrine issue that they could talk Jeremy Paxman round. The PAGB flyers are useful, and things will get a little easier when packaging has been updated, but a lot of patients remain unconvinced.

Family members, friends, the internet, GPs and NHS Direct will all be consulted for a second opinion. And it's usually easier to give that second opinion than the first. A patient referred to me by NHS Direct was one of my most satisfying consultations for a while. I simply reiterated what she'd been told on the phone, sold her an OTC medicine, and she left feeling hugely reassured and very grateful.

A sector of many parts

Many pharmacists would have read the statement from a government minister that pharmacy should play a greater role in the nation's healthcare – with decidedly mixed feelings. My first reaction, as a locum, was how on earth can you place extra duties and responsibilities on a manager or locum on top of the already monstrous workload under which so many are already struggling? The short answer must be that you cannot; the sector will probably develop in a way that sees the creation of what the press has already called 'super pharmacies', offering a full range of services to the public, while Joe Soap in the suburbs and housing estates plods on in his prescription factory. Yet, since the category M fiasco, with further threats of more clawbacks to come, no employer is going to employ additional staff, let alone pharmacists, to carry out any extra duties. They will attempt to bolt them onto the existing staffing level, with little or no increase in salaries or resources for doing so.

It is not too difficult to feel that community pharmacy has reached a crisis point in its relationship with central government. While the larger groups can weather the financial storm better than their smaller, perhaps privately-owned brethren, even they must be questioning whether the massive investment they have made in their pharmacies is really bringing in a worthwhile return for them and their shareholders. Pharmacy numbers may be expanding but that trend will almost certainly be reversed if employers cannot make the sums add up. Strangely, in many of the pharmacies in which I work, prescription numbers are actually falling or have stalled. Several are nothing like as busy as they were a couple of years ago and my experience of 100-hour pharmacies are that they are struggling to achieve acceptable prescription numbers even 12 months after opening. You cannot sensibly cover 16-hour staffing costs out of considerably less than 100 items a day and the build up of prescription numbers has been nothing like as successful as once thought possible.

Further, since the size of the pharmaceutical financial cake remains the same, sharing it among a larger number of pharmacies must mean everyone gets less – to the detriment of the whole sector.

When I read comments from pharmacy bigwigs in C+D and other publications about the opportunities becoming available to the sector, I often feel they make the great mistake of viewing community pharmacy as a cohesive whole. But it very definitely is not. It is a disparate sector made up of about 11,000 units, each with its own character, personalities and problems and with an enormous variation in its ability to take advantage of any opportunities presented. It does not matter whether it is owned by a large company or is in private hands, the disparity is considerable.

This prevents the sector from functioning as a cohesive whole and I fear that it never will. There will always be the most enormous variation in the ability of individual pharmacies to respond to opportunities in a monopolistic state-run healthcare system.

The sooner we all realise this fact, face up to it and above all plan accordingly, pharmacy will always present as a hotchpotch of successes, failures and missed opportunities.

On publications and profit ...

I view with some scepticism the reported euphoria around the publication of the pharmacy white paper, the Clarke report and the Galbraith report. The most significant of these, the white paper, seems to be remarkably short on financial detail.

I have been in pharmacy for 40 years and I learnt early on that one of the first things you do is accurately cost any new project – I assume this work has been carried out? But I am a little dismayed that we are again to be left to the whims and inefficiencies of PCTs, and that a working group will be set up to look at this specific issue. This seems a little like putting the cart before the horse.

Pharmacists of course want to take on these new roles, and it is right that our abilities are recognised – but we already do so much for nothing and I trust that the DH does not wish us to bail them out over the out-of-hours fiasco created by the GP contract!

Anne Galbraith gives us little of substance on the vexed subject of control of entry, suggesting it will "fall away" as PCTs take control of contractual arrangements.

The 100-hour situation is frankly farcical and the inadequate control of entry regulations leave contractors open to the financial pressures associated with property developers – not the providers of professional services.

The Clarke report strikes me of little value. The fact is, unless the Society offers more to its members it will not survive as a voluntary membership organisation – at best it will become marginalised.

So many of these developments depend upon the quality of the PCTs, but my experience nationwide is this quality is just not there.

The PCTs appear to me to be administratively top heavy and frankly in many cases they have no engagement with pharmacy.

So we continue to chase around for our £27 here, our £15 there, all the time required to make further investment on falling margins – and margin is what funds our professional activities!

Just today I had a patient return £930 worth of injections that were no longer required (and the patient had not died). Such reckless prescribing is scandalous and I suggest the DH would do well to address this before it squeezes every penny out of the supply chain.

We are constantly told by politicians that investment in the NHS has increased threefold in the last 10 years. My question is – how much of the money allocated to PCTs for pharmaceutical services actually gets to the point of delivery? Sorry to be a killjoy, but I remain to be convinced that this is the New Dawn!

Mike Smith FRPharmS, Budleigh Salterton

Letters

Please email us with your letters to:
haveyoursay@cmpmedica.com
Or write to the Editor at:
C+D, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE

C+D AWARDS 08

The judges have deliberated, entries have been marked and the shortlist for the C+D Awards 2008 can now be revealed

The shortlist

It's been tough, but the judging process is now complete and we can reveal that 39 entries have successfully made it through to the last stage of the C+D Awards 2008, run in association with the NPA. A further 24 entries will receive a Certificate of Merit in recognition of their achievement. The 39 short-listed entries will now be invited to the awards ceremony on Wednesday June 18, at London's Grosvenor House Hotel, where the winners of each category will be announced. So thanks to everyone who entered and good luck to those who have made it to the shortlist. To attend the party of the year and cheer on the winners see page 23 for how to get tickets.

Business Development of the Year

(Sponsored by GlaxoSmithKline)

- **Carter Chemist & Ability**, Northwood, Middlesex
- **Lime Tree/Shelley Community Pharmacy**, Worthing, West Sussex
- **Pharma Health Care**, Hornchurch, Essex

Dental Service of the Year

(Sponsored by Quantum Specials)

- **Boots The Chemist**, Aberdeen
- **Manor Pharmacy**, Ilkeston, Derbyshire
- **Pierremont Pharmacy**, Broadstairs, Kent
- **Tesco Pharmacy**, Welwyn Garden City, Hertfordshire

Dispensing Pharmacist of the Year

(Sponsored by Teva UK)

- **Fiona Eastop**, Lloydspharmacy, Burntisland, Fife
- **Amanda Jones**, Village Pharmacy, Harlington, Middlesex
- **Sion Llewelyn**, Rowlands Pharmacy, Bala, Gwynedd
- **Verinder Mehta**, Alliance Pharmacy, Slough, Berkshire
- **Valerie Sillito**, Boots The Chemist, Aberdeen

Dispensing Team of the Year

- **Lloydspharmacy**, Coventry, West Midlands
- **Mount Elgon Pharmacy**, Wimbledon Chase, London
- **Niton Pharmacy**, Niton, Isle of Wight

MUR Champion of the Year

(Sponsored by Pfizer)

- **Fiona Burns**, HI Weldricks, Elland, Halifax
- **Joan Graham**, Alliance Pharmacy, Danbury, Essex
- **David Smith**, Peak Pharmacy, Dronfield, Derbyshire

New Pharmacist of the Year

(Sponsored by Teva UK)

- **Aniket Parikh**, Clockwork Pharmacy, Hackney, London
- **Hatul Shah**, Carter Chemist & Ability, Northwood, Middlesex
- **William Swain**, HI Weldricks, Doncaster, South Yorkshire

Pharmacy Assistant of the Year

- **Pamela Cook**, Day Lewis Pharmacy, South Norwood, London
- **Amanda Wells**, Day Lewis Pharmacy, Erith, Kent
- **Danielle White**, Prestwich Pharmacy, Prestwich, Manchester

Pharmacy Manager of the Year

(Sponsored by Vitabiotics)

- **Nichola James**, Lloydspharmacy, Swansea, South Wales
- **Bernard Mweseka**, Day Lewis Pharmacy, North Woolwich, London
- **Lila Thakerar**, Shaftesbury Pharmacy, South Harrow, Middlesex

Pharmacy Team of the Year

(Sponsored by McNeil)

- **Buchanhaven Pharmacy**, Peterhead, Grampian
- **Prestwich Pharmacy**, Prestwich, Manchester
- **Rowlands Pharmacy**, Runcorn, Cheshire

Pharmacy Technician of the Year

(Sponsored by Actavis)

- **Pam MacPherson**, Rowlands Pharmacy, Portsmouth, Hampshire
- **Claire McCrindle**, Alliance Pharmacy, Girvan, Ayrshire
- **Lynn Tenan**, TC Cornwalls, Stafford, Staffordshire

Pre-registration Graduate of the Year

(Sponsored by Reckitt Benckiser Healthcare)

- **John-Patrick Foley**, Wylde Green Pharmacy, Birmingham, West Midlands
- **Paul Gunson**, HA Chemist, Liverpool, Merseyside
- **Ravi Patel**, Day Lewis Pharmacy, Biggin Hill, Kent

Retail Service of the Year

(Sponsored by T&R Care)

- **Lloydspharmacy**, Coventry, West Midlands
- **Murrays Healthcare**, Stourbridge, West Midlands
- **Prestwich Pharmacy**, Prestwich, Manchester

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Cystitis is an inflammation of the lining of the bladder as a result of infection, irritation or damage[2]. It is more common in women because their urethra is shorter, meaning bacteria can travel up it to the bladder more easily than in men. It is not usually serious if treated promptly, but can cause chronic pain and discomfort.

Onset of cystitis may be preceded by an itching sensation in the urethra. Other symptoms include:

- Dysuria – a painful, burning sensation when passing urine
- A frequent urge to urinate, even though there may be very little to pass
- Dark, cloudy or strong smelling urine
- A dragging ache in the lower back or abdomen

Bacterial infections, such as cystitis, produce acidic urine that causes dysuria. OTC treatments contain alkaline potassium or sodium citrate salts to neutralise the acidity and provide symptomatic relief.

Cymalon from Actavis is available in both handy sachets (sodium citrate) and cranberry liquid (potassium citrate), and offers women a choice for effective relief from the burning pain and irritation of cystitis to suit their needs and lifestyle. Both variants provide a 48 hour treatment and work by helping to neutralise urine acidity during an attack.

Ensure that Cymalon sachets are taken well diluted with water since this encourages more frequent emptying of the bladder and will help flush out infecting bacteria.

References:
1 C+D Feb 3 2007
2. www.nhsdirect nhs.uk
Health Encyclopaedia>>C>>Cystitis

Cymalon will be supported in 2008 with a nationwide marketing and PR campaign including educational advertorials in target women's media.

Cymalon Sachets cost £3.99 for 6 sachets (48 hour treatment)
Cymalon Cranberry Liquid 60ml costs £3.99 (48 hour treatment)

Points to consider

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- Customers present with any of the following symptoms or criteria, always refer them to their GP:
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  - If the urine contains blood.
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  - If the condition has persisted for more that two days following treatment.

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Cymalon Cranberry Liquid. **Active ingredient:** Potassium citrate 1.5mg/5ml. **Indications:** Relief of symptoms of cystitis and other mild urinary tract infections. **Dosage and administration:** Adults, elderly and children over 6 years: 10ml taken three times a day, well diluted with water after meals. Not recommended in children under 6 years. **Contraindications:** Pregnancy, hypercalcaemia, renal dysfunction, ventricular disorders and Addison's Disease. Hypersensitivity to ingredients. **Warnings and precautions:** May predispose to urinary tract stone formation. Diabetes (contains sucrose (2.2g) per 10ml). Contains alcohol (less than 100mg per 10mls dose). Avoid in fructose intolerance, glucose-galactose malabsorption or sucrose-isomaltase insufficiency. If symptoms persist 48 hours after treatment consult a doctor. **Interactions:** Cardiac glycosides, nitrofurantoin, potassium-containing or sparing medication. **Undesirable effects:** mild nausea, occasionally vomiting due to gastric irritation. **Market Authorisation Holder:** Thornton & Ross, Linthwaite Laboratories, Huddersfield HD7 5QH. PL 00240/0117. **Legal Status:** GSL **Date prepared:** April 2008. Consult SPC for full details.

C+D Clinical

Renal anaemia

This article describes features and treatment of anaemia associated with chronic kidney disease

Key points

- Anaemia is a common feature of patients with chronic kidney disease.
- Renal anaemia develops because of a failure in erythropoesis, though poor dietary iron intake and increased iron losses may also play a part.
- Renal anaemia is associated with a high incidence of cardiovascular disease, which accounts for more than 50 per cent of deaths in these patients.
- Erythropoetin (EPO) may be given between one and three times a week, and is more effective when administered subcutaneously rather than intravenously.
- Patients on ESA therapy will usually require intravenous iron supplementation.

Caroline Ashley MRPharmS

Chronic kidney disease (CKD) is increasingly being diagnosed and managed in primary care. There are five stages, ranging from near-normal renal function down to end stage kidney disease, where the patient will require dialysis (see table 1 overleaf).

How anaemia develops

Red blood cells (erythrocytes) are the most numerous in the blood and carry haemoglobin, which is responsible for transporting oxygen from the lungs to peripheral tissues via the circulation. The body controls the manufacture of erythrocytes, known as erythropoiesis, to maintain the serum haemoglobin (Hb) within a relatively tight range. The peri-tubular cells in the kidney are sensitive to oxygen levels in the blood, and they respond to hypoxia by increasing production of the hormone

The College of Pharmacy Practice

This course (module 1437), in association with multiple choice questions being published in C+D May 3, provides one hour's continuing education

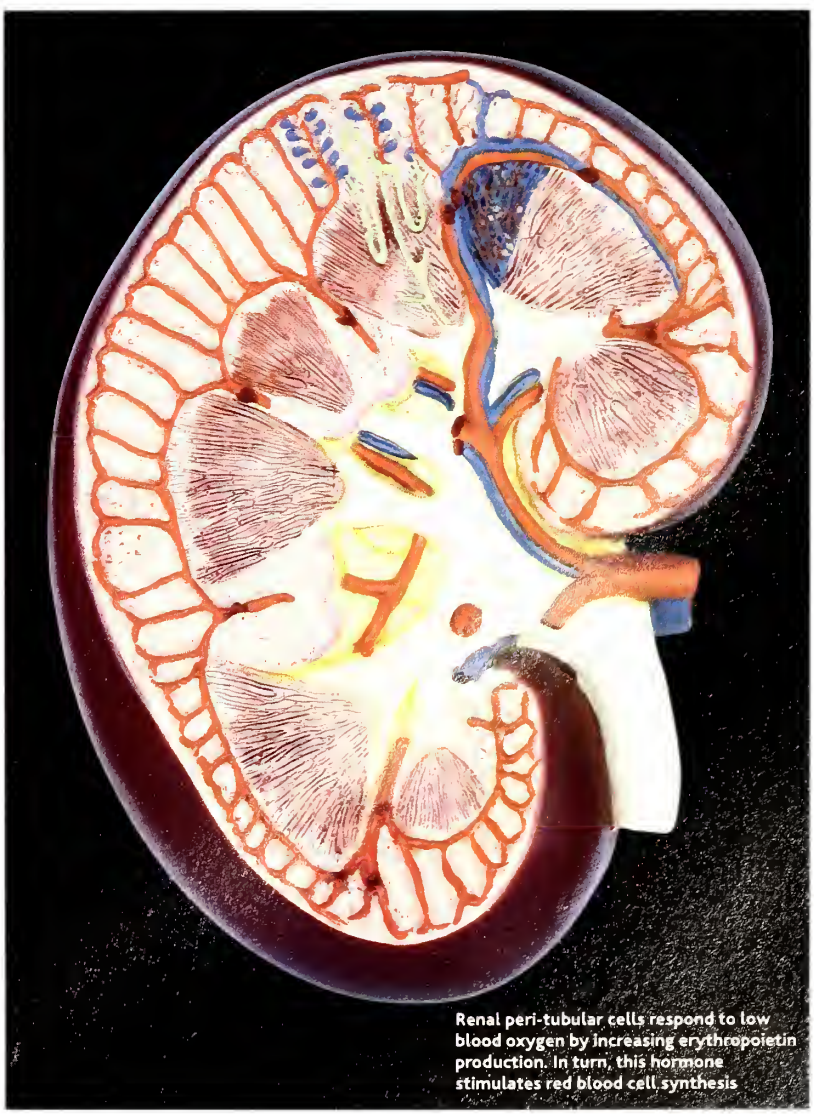
Reflect

Do you know why patients with chronic kidney disease are likely to suffer from anaemia? What complications can result? How is renal anaemia treated and monitored?

Plan

This article describes the causes, symptoms and management of renal anaemia.

CPD This article can help in the following CPD competencies: **G1a, G1c, C1a, C3a, C3e**. See www.tinyurl.com/194zu



Renal peri-tubular cells respond to low blood oxygen by increasing erythropoietin production. In turn, this hormone stimulates red blood cell synthesis

erythropoietin (EPO). Once released, EPO acts on progenitor cells in the bone marrow to stimulate red blood cell production. During erythropoiesis, these progenitor cells incorporate haemoglobin, then develop through immature red blood cells called reticulocytes into mature erythrocytes, losing their nuclei in the process. The erythrocytes have a mean half-life of up to 12 weeks in circulation, after which they are recycled.

Anaemia occurs when the serum haemoglobin concentration has been reduced to a level affecting tissue oxygenation. It is most commonly associated with either an inadequate iron intake in the diet or increased blood losses, such as in menstruating women or following trauma.

Blood transfusions may be administered to correct severe anaemia but, for most patients, supplementation with oral iron will restore serum Hb over a period of weeks to months. Anaemia may also occur in the absence of an underlying iron deficiency, due to a failure of erythropoiesis for other reasons. This is seen in chronic inflammatory conditions such as rheumatoid arthritis, a variety of vitamin deficiencies, some malignancies, and in CKD.

In the case of CKD, as renal function declines, so the ability of the kidneys' peritubular cells to synthesise and secrete EPO diminishes. Anaemia can appear at any stage of CKD, but its prevalence increases once the glomerular filtration rate (GFR) has dropped below 60ml/min/1.73m^2. From then on, there is a slow, progressive decrease in Hb concentration that becomes particularly evident once the GFR falls below 30ml/min/1.73m^2.

Other factors can contribute to, or exacerbate, renal anaemia. Iron deficiency is common in renal failure because of poor dietary intake and increased iron losses; the latter is caused by increased blood loss, mainly in the gastrointestinal tract, since uraemia is associated with platelet dysfunction.

For example, patients on dialysis often lose three to 4mg iron/day compared with the normal daily iron loss of 1mg. In addition, hyperparathyroidism is a complication of renal failure, and exacerbates anaemia by inhibiting erythropoiesis and causing fibrosis in the bone marrow.

Aluminium hydroxide is still used in the management of renal bone disease, although it is being superseded by newer phosphate binders. However, aluminium toxicity interferes with haem synthesis and can cause microcytic anaemia. In many patients with uraemia, red blood cell life-span is reduced because of low-grade haemolysis. Folate deficiency, resulting from poor dietary intake and excessive loss of folic acid during dialysis, can also exacerbate anaemia.

Table 1. The five stages of chronic kidney disease

Estimated glomerular filtration rate (ml/min/1.73m^2)	Stage of chronic kidney disease
90	Normal kidney function (early kidney disease may or may not be present)
60-90	Mild
30-59	Moderate
15-29	Severe
<15	End-stage kidney disease

Clinical features

Patients with long-standing renal anaemia complain of tiredness, lethargy, muscle fatigue, reduced exercise capacity, poor concentration, impaired memory and intellectual ability, breathlessness, angina, palpitations, appetite loss, reduced libido and a sensation of feeling cold. Renal anaemia contributes to the high incidence of cardiovascular disease seen in renal patients, which accounts for more than 50 per cent of deaths in this group. Other common factors associated with renal cardiovascular mortality include chronic fluid overload, left ventricular hypertrophy, hypertension, hyperlipidaemia, vascular calcification and diabetes.

Diagnosis

Healthy adults have serum Hb concentrations in the range 12-15g/dL for females and 14-18g/dL for males. The European Best Practice Guidelines suggest that investigation of anaemia in CKD should begin when Hb falls below 11.5g/dL in females and 13.5g/dL in males (12g/dL in males over 70 years of age). In contrast, both the UK Renal Association and Nice take a slightly different approach, recommending that anaemia should be checked for when a patient reaches stage 3 CKD. In a patient with a GFR<30ml/min, it is reasonable to assume that the anaemia is secondary to renal failure. Nevertheless, it is important to exclude other contributory causes such as iron deficiency, gastrointestinal blood loss or malignancy.

Management

Before the advent of EPO therapy, haemoglobin levels were normal in only about 3 per cent of patients requiring dialysis; in most patients, the serum Hb level was typically six to 8g/dL. Thus, until the late 1980s, most dialysis patients required regular blood transfusions. This had the disadvantages of causing fluid and iron overload, enabling virus transmission and sensitising patients to foreign blood-borne antigens, thereby greatly decreasing the chance of a successful transplant.

Current recommendations are that treatment with an erythropoiesis stimulating agent (ESA) should start once the Hb level falls below 10 to 11g/dL, with a recommended target for CKD patients of about 11 to 12g/dL. There is evidence that targeting Hb levels >13g/dL (ie near normal) may be harmful and result in an increased risk of cardiovascular events. Similarly, to reduce the risk of adverse events, an increase of about 1g/dL/month is appropriate.

ESA therapy is effective in correcting the anaemia of renal failure in 90 to 95 per cent of patients, which in turn improves myocardial ischaemia and reduces left ventricular mass. Improvements in quality of life and in cognitive, sexual, immune and endocrine function are also seen.

Erythropoietin is a large glycoprotein containing 165 amino acids. It is inactive when administered orally, so must be given by either intravenous or subcutaneous injection. The usual starting dose is about 2,000 units two to three times a week, and patients can generally be taught to self-inject. The haemoglobin concentration usually begins to increase from two weeks onwards. Of the recombinant human EPOs available in the UK, EPO-alfa (Eprex) was the first, appearing in the late 1980s, followed by EPO-beta (NeoRecormon) a few years later. Recently, EPO-delta (Dynepo) and EPO-zeta (Retacrit) have been launched, as well as the first biosimilar product, Binocrit, which is effectively a generic version of EPO-alfa. Clinically, they are all indistinguishable. However, it is advisable for a patient to remain on a particular brand in order to avoid confusion, as the delivery systems vary slightly between brands.

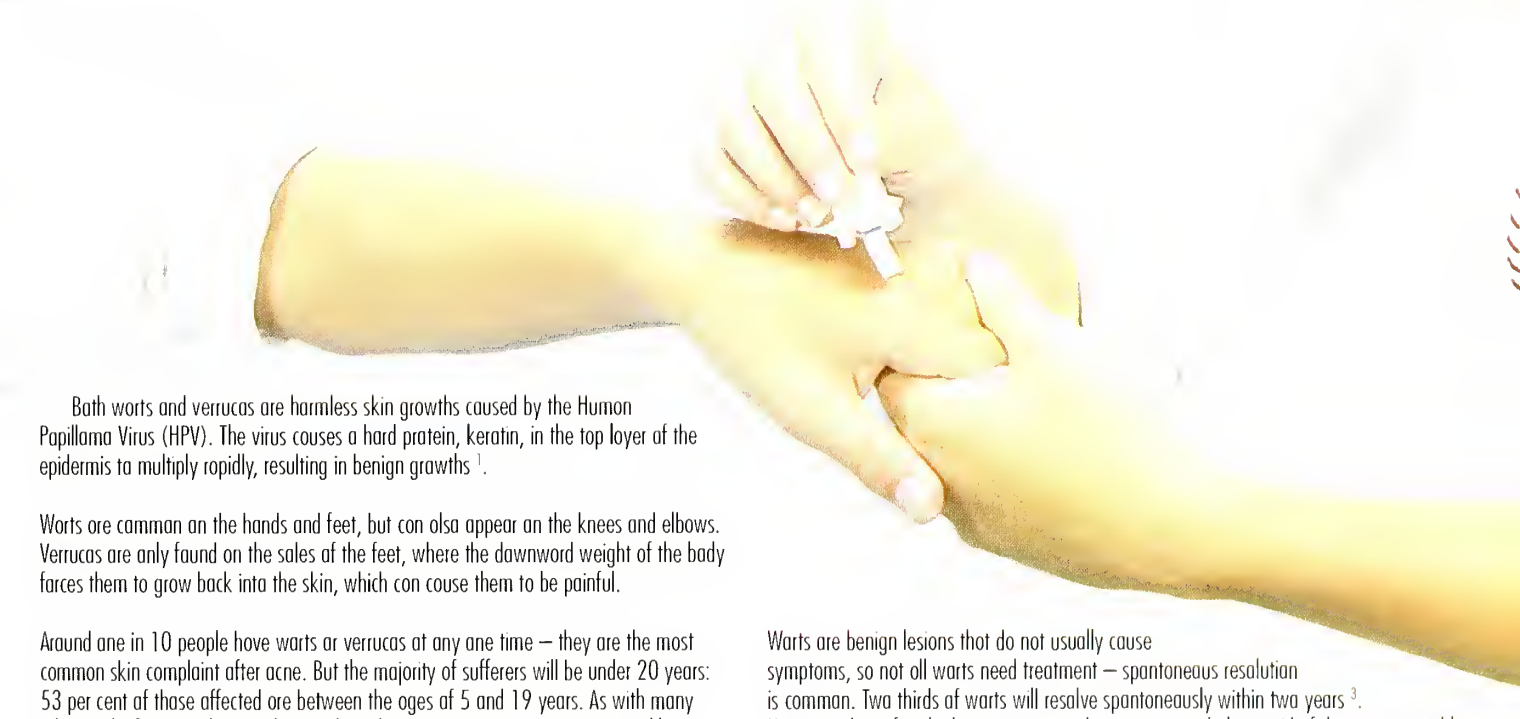
EPO is usually administered once, twice or, most commonly, three times a week. It is most effective when administered subcutaneously, with doses approximately 25 per cent lower than when given intravenously, although patients on haemodialysis may prefer the latter route.

Darbepoetin-alfa (Aranesp) is a second generation ESA. It is a hyperglycosylated analogue of EPO-alfa that differs from

WARTNER

Warts 'n all

Warts and verrucas have traditionally been treated OTC with topical preparations of salicylic acid, glutaraldehyde or podophyllin. Now another option, ***cryotherapy****, is available.*



Bath warts and verrucas are harmless skin growths caused by the Human Papillama Virus (HPV). The virus causes a hard protein, keratin, in the top layer of the epidermis to multiply rapidly, resulting in benign growths [1].

Warts are common on the hands and feet, but can also appear on the knees and elbows. Verrucas are only found on the soles of the feet, where the downward weight of the body forces them to grow back into the skin, which can cause them to be painful.

Around one in 10 people have warts or verrucas at any one time – they are the most common skin complaint after acne. But the majority of sufferers will be under 20 years: 53 per cent of those affected are between the ages of 5 and 19 years. As with many other viral infections, those with a weakened immune system are more susceptible.

The common wart (*verruca vulgaris*) and verruca (*verruca plantaris*) are the two types of wart most commonly seen, but there are a variety of presentations (see panel overleaf).

Management Issues[2]

Warts are contagious, so emphasise to customers that prevention and limiting the risk of spread is important. The risk of transmission is not clear, but is presumed to be low. For this reason people with warts and verrucas should not be excluded from activities such as sports or swimming. However, advise sensible precautions such as:

- Cover with a waterproof plaster when swimming
- Wear flip-flops in communal showers
- Avoid sharing towels

Since the infection is viral, limiting the risk of skin-to-skin self-infection is also important. Advise customers not to scratch their warts to minimise viral shedding, and to keep feet dry and change socks daily to prevent verrucas spreading.

Warts are benign lesions that do not usually cause symptoms, so not all warts need treatment – spontaneous resolution is common. Two thirds of warts will resolve spontaneously within two years [3]. However, they often look unattractive and treatment can help get rid of them more quickly.

Treatment can be an option if:

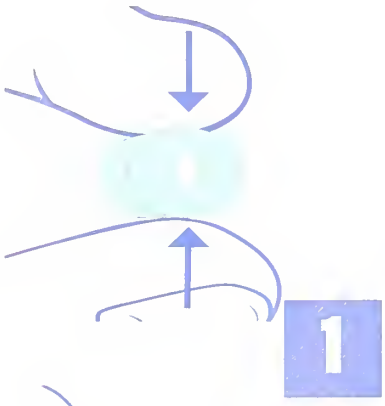
- The wart is visible and unsightly
- The wart (verruca) is causing pain and affecting walking
- The wart is slow to clear (warts are slower to clear in adults and those that have been present for a long time are less likely to clear spontaneously)[2]

OTC treatments for warts and verrucas have, in the main, been based around topical salicylic acid. Compliance is an issue, because treatments are not always straightforward to apply. The skin should be softened by soaking in warm water, the area over the wart or verruca should be filed to remove hard skin, and a plaster may be needed to cover the area once the application is dry to prevent it rubbing off or damaging clothing. Additionally, treatment may need to be applied daily for up to 12 weeks.

Cryotherapy is a relatively recent OTC option that mimics the liquid nitrogen freezing treatment offered in clinics. Instead of nitrogen (at -196°C) OTC products such as Wartner Wart or Verruca Remover, use dimethyl ether and propane (at -57°C).

When to refer...

- **Don't advise self-treatment of filiform or genital warts – refer the customer to their GP, or a GUM clinic as appropriate**
- **Don't advise self-treatment of facial warts – salicylic acid can cause irritation and scarring if the skin is thin**
- **Avoid cryotherapy and salicylic acid in customers who have poor circulation (e.g. diabetes). Refer them to their GP or a chiropodist**
- **If you are not sure of your diagnosis, refer them to their GP**
- **If the customer presents with a bleeding wart or verruca, or reports that it is changing in appearance or spreading, refer them to their GP**



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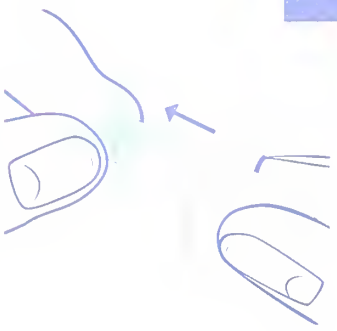
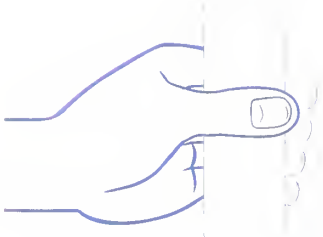


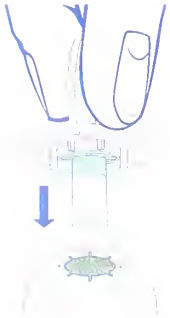
Please note the guide below is specific to Wartner products not OTC cryotherapy as a whole

- Hold the blue end of the foam applicator between the thumb and index finger, squeeze until on opening appears, then slide the foam onto the stick of the applicator holder until the stick is no longer visible.
- Hold the aerosol, in an upright position and oway from your body. Place the applicator holder into the opening in the top of the oerosol, and press the opplicator holder down firmly for THREE seconds.
- You will hear a hissing sound as the foam applicator is saturated with cold liquid from the aerosol. Remove the applicator – condensation will form but this is hormless.
- Immediately after removing the foam applicator from the top of the aerosol, position the foom tip over the wort and push down lightly with the applicator holder. Ensure constant contact with the areo to be treated.
- Treat for the required time (see table). A slight aching or stinging sensation may be felt as the wart (*verruca plantaris*) is frozen. Determine treatment time from the chart below.
- After treating the wart, wait for two minutes before using a tissue to remove the foam applicator from the holder. Discard – do not re-use or touch the tip of the foam applicator with bare hands to ensure that the skin is not re-infected with the wort virus.



2

Type of wart or verruca	Wart or verruca diameter	Treatment time
Common warts and verrucas on toes and arch of foot	Smoller than 2.5 mm	10 seconds
Common warts and verrucas on toes ond arch of foot	From 2.5 mm to 5.0 mm	15 seconds
Common warts and verrucas on toes and arch of foot	Larger than 5.0 mm	Maximum of 20 second
Verrucas (colloused) on heels and bolls of foot	All sizes	Moximum of 40 seconds



3

Maximum application times for verrucas on various parts of the foot

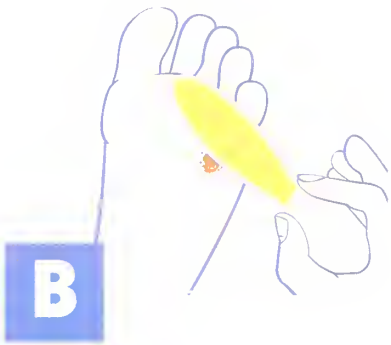
4

20 Second Area
arch and toes

40 Second Area
heel and ball of foot

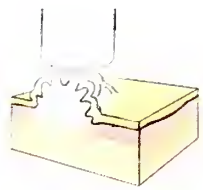
Treating Verrucas with Wartner

- Verrucas can be tougher to treat than warts since the skin is thicker on the soles of the feet, so before treating soak the foot in warm water for five minutes.
- Then rub the callous with the re-usable file provided in the Wartner Verruco Remover pack to expose the verruca. Proceed with treatment as outlined on the opposite page.
- Use a comfort pod (included in the pack) if necessary to protect the treated verruca. Apply the adhesive side of the pad to the skin with the hole directly over the treated verruca.

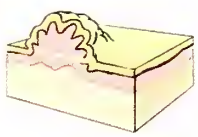


What you will feel and see...

When the foam applicator is pressed onto the wart or verruca the treated skin will turn white. A slight aching or stinging sensation may occur as a result of the freezing. However, after removing the applicator, the colour loss and aching or stinging sensation will decrease rapidly.

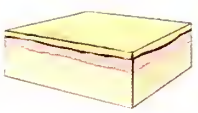


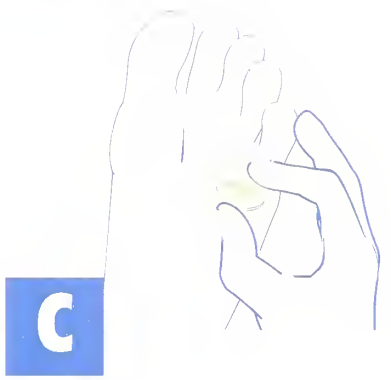
As a result of freezing, a blister will form under the wart or verruca. This may not be visible to the naked eye where the skin is thick. The treated wart or verruca should gradually disappear or fall off within 10 to 14 days, revealing new healthy skin underneath.



Usually only one treatment is necessary. However this depends on the size and age of the wart or verruca (refer to the in pack leaflet). In persistent cases, the treatment can be repeated after two weeks.

Do not treat the same wart or verruca with cryotherapy more than three times. Customers should be advised to consult their GP if three treatments have not led to an improvement.

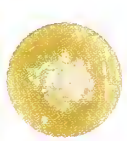




Types of Wart

Common warts (*verruca vulgaris*) appear as a firm raised lump with a rough surface that may be segmented to give a cauliflower-like appearance. They can be round or irregular in shape, and can grow up to 10mm in diameter. They are most common on the fingers, knees and elbows.

Verrucas (*verruca plantoris*) are found on the bottom of the foot. They can be painful to walk on, and are often larger and flatter than common warts because of the pressure on the bottom of the foot. Verrucas often have a small black dot at the centre. This is not, as some people believe the 'root' of the wort, but are caused by bleeding in the verruca as a result of walking on it.



Plane warts (*verruca plana*) are round, flat topped or slightly raised. They can appear on the face or the hands, especially around the nails and fingers.

Filiform warts (*verruca filiformis*) present as long slender growths that are common on the thinner skin of the armpits, neck or face. These warts should not be treated with OTC preparations.

Water warts (*molluscum contagiosum*) appear as smooth raised white or translucent lumps. In children they appear mainly on the body, arms and legs, often in clusters.

Genital warts (*condylomata acuminate*) manifest as small white lumps or cauliflower growths around the genitals or anus. They are transmitted through sexual contact and anyone you suspect of having genital warts should be referred to their GP or local GUM clinic.

WARTNER

a safe and fast treatment for warts and verrucas

Cryotherapy for treating warts and verrucas has been used in clinics for some years. Now the same option is available OTC with Wartner Wart Remover and Wartner Verruca Remover, indicated for the treatment of common warts and verrucas.

Cryotherapy is thought to clear warts either by destroying the epidermal keratinocytes that are infected by the Human Papilloma Virus or, alternatively, by causing local inflammation that leads to a localised immune response[3].

The wart or verruca is not immediately frozen, or 'burnt off'. The freezing breaks down the skin tissue and a blister is formed that isolates the problem area. The dead tissue falls off within 10 -14 days.

A clinical study to compare the efficacy and safety of liquid nitrogen with the dimethyl ether/propane (DMEP) mixture used in Wartner products shows that both cryogenic agents were >90 per cent effective (*F. Cabollero Martinez et al. Dermatological cryosurgery in primary care with dimethyl ether propane in comparison with liquid nitrogen*). While liquid nitrogen boils at -196°C, DMEP does so at -57°C, and is less likely to cause deep tissue damage.

Do's and Don'ts with Wartner Cryotherapy

- If there are multiple warts or verrucas close to each other, treat only one at a time. Treat each remaining wart/verruca separately with a two week interval between each.
- Old and large warts or verrucas can be difficult to remove and may require more than one treatment. If more than one treatment is required, leave an interval of two weeks.
- Overuse and over-exposure to freezing can damage the skin and lead to scarring and nerve damage, so stick to recommended treatment periods and exposure times.
- Do not use on children under 4 years of age.
- Cryotherapy should not be used by:
  - Pregnant or breastfeeding women
  - Diabetics or those with poor or impaired circulation
- Cryotherapy should not be used on:
  - Thin or sensitive skin (e.g. the face or genitals)
  - Irritated, infected or damaged skin
  - Warts with hairs growing from them
  - Birthmarks or pigmented skin
  - Dark moles

Wartner Wart Remover and Wartner Verruca Remover

- A Class IIa medical device for the removal of warts and verrucas
- Contains dimethyl ether and propane
- Two separate variants
  - **Wartner Wart Remover (RSP £11.95)**
  - **Wartner Verruca Remover (RSP £12.95)**

Wartner USPs

- Application system allows precise treatment without leakage and therefore reduces possible damage to healthy skin
- Freezes warts and verrucas to the core in one treatment*
- Safe and easy to use
- Based on the freezing method used by GPs
- Contains up to 12 applications
- The variant for the treatment of verrucas includes a reusable file and comfort plasters

* Old or large warts and verrucas may need more than one treatment

WARTNER

For further information contact:

Chefaro UK Ltd, 3 Percy Road, Huntingdon, Cambridgeshire, PE29 6SZ.
Email: enquiries@chefaro.co.uk Visit: www.wartner.co.uk

[1]NHS Direct Health Encyclopoedia: Warts
[2]www.CKS .library.NHS.UK. Warts – management issues
[3]Sterling, J.C., Handfield-Jones, S. and Hudson, P.M. (2001) Guidelines for the management of cutaneous warts. *British Journal of Dermatology* 144(1), 4-11.

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recombinant EPO by the substitution of five amino acids and the addition of two extra N-linked sialic acid-containing carbohydrate side chains. These changes make the molecule more stable *in vivo*, giving it a longer half-life than conventional EPO (25.3 hours vs 8.5 hours), which means it can be administered once a week or even every two weeks. Moreover, the intravenous and subcutaneous doses are equivalent. The appropriate conversion factor is about 200 units of EPO to 1mg darbepoietin-alfa, though this ratio may increase at higher doses.

Continuous erythropoietin receptor activator or CERA (Mircera) is the latest ESA. CERA is an EPO-beta analogue incorporating a large pegylated chain. It has an extremely long half-life (around 139 hours), so is administered once every two weeks during the correction phase of anaemia therapy, and once every four weeks during the maintenance phase. More clinical experience is needed with this new product before its use becomes widespread.

All ESAs require long-term refrigerated storage, although CERA may be kept at room temperature for a month. Because of the high cost of these agents, correct storage and avoidance of a break in the cold chain are essential.

Side effects

There are few adverse effects to ESA therapy, and most of these are thought to result from an increase in haematocrit and blood viscosity rather than as an effect of the ESA itself. The most common side effect is hypertension, seen in about 20 to 30 per cent of patients. Other reported side effects include thrombosis of vascular access for dialysis, clotting of dialysis lines, myalgia, flu-like symptoms and skin irritation around the injection site.

About four to five years ago, there was a substantial increase in the number of reports of pure red cell aplasia (PRCA), with the formation of anti-EPO antibodies in patients receiving EPO therapy (particularly EPO-alfa). The reason for this is not clear, but is thought to be related to a change in formulation of the drug vehicle, which caused an interaction between the vehicle and the bung in the pre-filled syringe, destabilising the EPO molecule and rendering it more antigenic. The anti-EPO antibodies not only neutralise the therapeutically administered EPO, regardless of the brand used, but also the patient's own endogenous EPO, resulting in a severe transfusion-dependent anaemia. This problem has more or less been rectified, and now PRCA is only occasionally reported.


AJ Photo/Science Photo Library

Iron supplementation

Iron deficiency is common in patients with CKD, and supplementation is often required. It is important to monitor the patient's iron status regularly, by measurement of serum ferritin, transferrin saturation or percentage of hypochromic red blood cells. Although oral iron is simple

Your Continuing Professional Development CPD

Act

- Read more about the doses and precautions of EPO products in the BNF (section 9.1.3).
- Read the Nice quick reference guide www.nice.org.uk/CG39.
- Read the information for the public on the same site. Make sure you could answer the 'Questions you might want to ask about ESA treatment' in case patients put the same queries to you.
- Nice (above) warns against taking supplements of vitamin C, folic acid or carnitine in renal anaemia of CKD. What are the reasons?
- Look at the UK National Kidney Federation's website www.kidney.org.uk for useful background information for yourself and your patients, such as a 'Know your numbers' section, which outlines the laboratory tests used to monitor renal function, while the medical information section gives lifestyle advice such as when to exercise. There is also a link to the Royal College of GPs' patient leaflet entitled CKD: What it is – What it Means.

Evaluate

Are you now able to discuss with patients on ESA therapy the rationale behind their treatment and its possible side effects?

MUR tips

For a short MUR guide on renal anaemia, download the PDF of this article at www.chemistanddruggist.co.uk/update

C+D is also shortly launching a collection of MUR guides on common conditions and you can ensure you do not miss out on this by signing up at www.chemistanddruggist.co.uk/register

CPD Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the May 3 issue, which will cover this month's three CPP-accredited modules.

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on **01732 377269**.

Chemist+Druggist in association with Genus Pharmaceuticals

C+D GENUS PHARMACEUTICALS

EPO is most effective when administered subcutaneously, but patients on haemodialysis may prefer the intravenous route

and cheap to use, gastrointestinal absorption of iron in CKD patients is usually impaired. Most patients, therefore, require intravenous iron, most commonly either iron sucrose or iron dextran. Adverse effects of intravenous iron include anaphylactic reactions, transient flushing, hypotension, dizziness, myalgia, arthralgia and abdominal pain. It is essential to ensure a patient is iron replete while on ESA therapy as, without sufficient available iron stores, the patient will not be able to manufacture Hb and hence not respond to the ESA.

Conclusion

Treatment of renal anaemia with ESAs has become standard therapy for patients with stages 4 and 5 chronic kidney disease. However, it is now routine for GPs to receive reports of their patients' GFR so patients with stage 3 CKD are now being identified. There is still some controversy as to whether these patients should then have their CKD managed by their GP or be referred to a nephrologist. Notwithstanding this dilemma, the use of ESAs is likely to become much more widespread within the primary care setting in the next few years.

Caroline Ashley MRPharmS is lead pharmacist for renal services at London's Royal Free Hampstead NHS Trust

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2. Joint Specialty Committee on Renal Medicine of the Royal College of Physicians and the Renal Association, and the Royal College of General Practitioners.
3. Chronic kidney disease in adults: UK guidelines for identification, management and referral. London: Royal College of Physicians 2006.
4. National Institute for Health and Clinical Excellence. Anaemia management in people with chronic kidney disease. Clinical guideline 39. London Nice, September 2006.

A Practical Approach — Ear problems

"So how was your holiday?" Hannah, senior medicines sales assistant at Update Pharmacy, asks fellow assistant Rebecca. "Was it really warm and sunny?"

Rebecca replies "Yes, it was lovely, but it was spoiled a bit."

"Why was that?"

"Poor Brian went deaf in one ear. He was really worried and it spoiled things for all of us. He rushed round to the doctor as soon as we got back, and has been told to get something to loosen the wax in his ears and come back in a few days for the nurse to syringe them. So I'm going to ask Mr Spencer what's the best thing to buy. But it's funny, because when we got back my dad told me he's got a problem with his ears too."

"Oh dear," says Hannah. "What is it?"

"He said he's got this popping noise in them, like that old TV ad for breakfast cereal – you know, 'snap, crackle and pop'."

"Has he got it all the time?"

"No, apparently it comes and goes, and it's not painful. He's a bit worried, but said he'd feel silly

David Farrant

going to the doctor about it, so he asked me to ask Mr Spencer if he might know what it was."

Questions

1. What is the exact cause of Brian's deafness?
2. What is available for softening ear wax, and what is the most effective?
3. What is the cause of Rebecca's dad's problem?
4. What is the treatment for it?

Answers

1. Brian probably went swimming on holiday, and had wax building up in his ear for some time before. Water either pushed the wax tight up against the ear drum, preventing it from vibrating and transmitting sound impulses along the auditory pathway, or it became trapped between the wax and the eardrum, with the same effect.

2. Constituents of cerumenolytic products include: fixed and volatile oils, as wax solvents; glycerol, as a softener; docusate, a surfactant facilitating the penetration of water; urea hydrogen peroxide, which reacts with naturally produced catalase enzyme to release oxygen and help break up wax mechanically, while urea aids penetration; paradichlorobenzene, claimed to assist penetration of oils into wax plugs. Little difference in efficacy has been found between cerumenolytics, and it has been reported that they are no more effective than using warm water or salting shortly before syringing. The BNF recommends olive oil, almond oil, or sodium bicarbonate ear drops.

3. Eustachian tube dysfunction (ETD). The Eustachian tube becomes blocked with thick mucus as a result of upper respiratory tract infection. The crackling or popping is due to the mucus moving within the middle ear.

4. Regular steam inhalation with the mouth open, to allow the maximum amount of steam up into the nasal passages and eustachian tube, until the ears can be heard cracking or the nose starts to run. The nose should then be blown one nostril at a time until all mucus is cleared. A sympathomimetic decongestant in oral or nasal spray form can also be used.

This article can help in the following CPD competencies: **G1a, G1d, C1a, C1f, C4h.** See www.tinyurl.com/194zu

Glucose monitoring in type 2 diabetes 'not effective'

Self-monitoring of blood sugars in patients with type 2 diabetes causes anxiety and depression, and may not offer any benefits, according to the results of a new trial.

The results of a randomised controlled trial published by the BMJ showed no improvement in either blood glucose levels or in the incidence of hypoglycaemia in the trial's self-monitoring arm.

It also revealed higher levels of depression and anxiety in the self-monitoring arm of the trial. Also, patients found self-monitoring uncomfortable, intrusive and unpleasant.

The authors reported that there was no convincing evidence for routinely recommending self-monitoring in patients with non-insulin dependent type 2 diabetes.

In an accompanying BMJ editorial article, Professor Martin Gulliford of King's College said the £100 million a year spend on testing strips should be redirected to controlling blood pressure, cholesterol, smoking, obesity and lack of exercise.

Self-monitoring of blood glucose is associated with anxiety, the study suggests

However, Diabetes UK care advisor Libby Dowling said every patient was different, and that for many type 2 diabetes patients, daily glucose measurements were useful in making daily adjustments aimed at controlling blood sugars.

Self-monitoring is widely advocated in type 2 diabetes, and is said to be the largest single management cost associated with implementing intensive glucose control (http://tinyurl.com/463dmg).

● An article in the latest MeReC Monthly considers whether intensive glucose control is beneficial, following a study revealed that intensive lowering could increase risk of death. http://tinyurl.com/3gmun2

Clinical News

NHS Direct tackles meds

NHS has launched a medicines health zone on its website, giving detailed information on common prescription-only and OTC treatments. The organisation reports that around half of the telephone calls it receives involve queries about medicines.

Promising psoriasis trial

A calcineurin inhibitor similar to ciclosporin has shown promise in a phase 3 trial for plaque psoriasis. ISA247 was found to be effective and well tolerated both at 12 and 24 weeks in patients with moderate to severe disease. www.thelancet.com

RIO data looks good

The cardiovascular benefits of rimonabant appear to continue with longer-term use. Two-year data from the rimonabant in obesity (RIO) study showed improvements in parameters such as HDL-cholesterol, triglycerides and waist circumference, as well as weight loss, and the drug appeared to be well tolerated. http://eurheartj.oxfordjournals.org/cgi/content/abstract/ehn076

Men C deaths eradicated

Adding the meningitis C vaccine to the UK childhood immunisation programme has reduced the death rate from the disease in under 19s to zero during 2006, the Department of Health has claimed.

The director of immunisation's report published this week shows that the introduction of the meningococcal C conjugate vaccine in 1999 has reduced Men C cases by 95 per cent.

More than 500 deaths have been prevented, and there were no deaths at all from Men C in the under 19s last year, the report goes on to say.

The pneumococcal conjugate vaccine has also been hailed a success. Its introduction in 2006 has prevented an estimated 470 cases of serious illness or mortality in young children.

Further, attitudes to the MMR jab also appear to be changing, with more than 85 per cent of children receiving one dose of the vaccine by their second birthday, and 73 per cent of parents considering it safe – a rise of 10 per cent in four years.

Patients being misled on complementary medicines

Patients are being badly misled by both sides of the argument on complementary medicines, according to a leading academic writing in the journal BMJ Clinical Evidence.

In the article, Professor Edzard Ernst argued that patients were being misled by sceptics who frequently ignored the evidence for complementary medicines.

However, proponents of alternative therapies too often claimed that the requirements of scientific evidence could not be applied to complementary medicine.

Also, while mainstream journals rarely published positive findings, complementary medicine journals rarely published any that were negative.

Clinical Alerts

New Products

Pradaxa capsules (dabigatran etexilate) Indicated for the primary prevention of venous thromboembolic events in adults who have undergone total hip or knee replacement surgery. Available in 75mg and 100mg strengths in pack sizes of 10 and 60 capsules. Boehringer Ingelheim, tel: 01344 424600.

Nutramigen AA 400g Amino acid-based hypoallergenic formula for infants and children with severe cow's milk protein allergy or multiple food intolerance. Mead Johnson Nutritionals, tel: 01895 523764.

SPC Changes

Maxalt range (rizatriptan) Serotonin syndrome added to side effects.

Forsteo 20mcg/80µl prefilled pen for injection (teriparatide) Now indicated for the treatment of osteoporosis associated with sustained systemic glucocorticoid therapy in women and men at increased risk of fracture. Warning added on the need for women of childbearing potential to use effective contraception during treatment.

Imigran range (sumatriptan) Common dyspnoea added to undesirable effects.

Humatrope solution for injection (somatropin) Warning on use in elderly patients altered from 60 years to 65 years.

Solu-Cortef vials (hydrocortisone) Psychiatric reactions warning added.

(methylprednisolone) Warning added about the possibility of psychiatric side effects occurring.

Depo-Medrone and Solu-Medrone ranges (methylprednisolone) Psychiatric reactions warning added.

Hydrocortone 10mg and 20mg tablets (hydrocortisone) Transferred from Merck Sharp & Dohme to Auden Mackenzie with immediate effect.

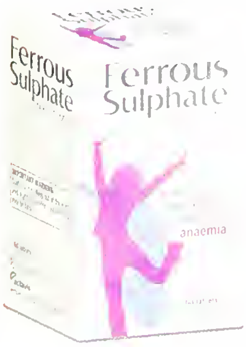
www.emc.medicines.org.uk

Discontinued Products

Beclazone and Beclazone Easi-Breathe inhalers (beclometasone) Range being discontinued because of move to CFC-free inhaler devices. Stocks expected to last until 2009. Teva UK Ltd, tel: 0113 238 0099.

More OTC choice

Ferrous sulphate has been added to the Actavis OTC portfolio. The product can be used for the treatment and prevention of iron-deficiency anaemia, a condition found in 8 per cent of women in the UK, says Actavis. Dietary changes are responsible for a fall in iron intakes over the past 20 years, it adds.



Containing 200mg dried ferrous sulphate, each tablet supplies the equivalent of 65mg elemental iron.

Price: £2.99/60
Pip code: 113-6399
Actavis
Tel: 01271 311200

Show head lice the X.it

The X.it range of head lice treatments has been updated with a new image and expanded with the addition of a metal comb. The blend of essential oils including tea tree, lavender and eucalyptus, claims a 92 per cent success rate after one application.

The brand hopes the new look will take full advantage of the consumer trend for natural, non-pesticide head lice treatments.

A laminated A4 training leaflet is available. Plans are in place for media activity and price promotions in September, the key selling period for head lice products.

The range comprises the Wet Combing System in three and eight-application pack sizes, Repellent Spray and the new comb.

The products are newly available via AAH Pharmaceuticals.

Prices and Pip code: comb 334-1633, £9.99
X.it Head Lice Solutions Ltd
Tel: 01484 711112
info@xitheadlice.co.uk

Bedfont unveils CO monitor

The Micro+ Smokerlyzer carbon monoxide monitor for use in the pharmacy has been launched by Bedfont Scientific. A one-touch conversion to foetal COHb makes the device suitable for testing pregnant women, as well as other adults and adolescents. For patients unable to hold their breath, the monitor has an adjustable breath-hold countdown timer. Single-use cardboard mouthpieces, an antibacterial filter and one-way valve contribute to the Micro+'s infection control facility. Results can be viewed as a table or graph and up to 10 patients' results stored.

A £100 trade-in is available against old breath CO monitors.

Price: £380
Bedfont Scientific
Tel: 08700 844050

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Designed to aid dispensing

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for PHARMACY STAFF

Retail Skills for Pharmacy Staff is a distance learning course from *Chemist + Druggist* and Hamacher Group, supported by SSL International, to improve the general retailing skills of pharmacy staff.

- One folder of 10 modules can be shared among staff. Individual workbooks are issued to staff members on registration
- Content based on Pharmacy Services NVQ2 – complements product knowledge learnt in MCA courses such as Counterpart

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OR complete the form below

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Card Type(Visa/Mastercard/Switch/AmEx):

Card number

Expiry Date

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Date

	Number	Total
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Number of sets @ £41.13 (inc VAT).		£
Course registration fee		
Number of staff @ £47.15 (inc VAT)		£

Name

Name

Name

Total payment £

Products in brief

Sweeter dreams

The Snoreeze range has been extended with the launch of a nasal strip variant. Designed to eliminate snoring caused by nasal congestion, the strips are applied before going to bed and work by opening the nasal passages and improving airflow. They are hypoallergenic and are available in two sizes: small/medium and large. The strips can be used in conjunction with Snoreeze throat spray, nasal spray or oral strips for maximum effectiveness, says manufacturer Passion for Life.
Price: £8.99/20; Pip code: sm/med 33S-3190; large 33S-3182
Passion For Life Healthcare
Tel: 01372 847272

Savlon's skin cooler

First aid brand Savlon has launched an aftersun foam spray. It is applied without having to touch the skin, is soothing, cooling and moisturising on contact and helps prevent peeling. The moisturising agent dexpanthenol is included to accelerate cell renewal, says manufacturer Novartis. The Savlon brand is being supported with a £2 million campaign this year. Price: £6.99/150ml; Pip code: 334-0239
Novartis Consumer Healthcare
Tel: 01403 218111

Balmy launch

New additions to the Badger Balm range from Graftons include Mind Balms and a Night-night variant for children. The three Mind Balms – headache soother, stress soother and yoga and meditation balm – are presented in 1oz tins. They contain natural ingredients including essential oils. The Night-night balm is said to promote feelings of safety, cheerfulness and calm to help youngsters settle down to sleep.
Prices: see C+D Monthly Pricelist
Grafton International
Tel: 01827 280080

Lil-lets pad makes debut

A range of sanitary pads has been added to the Lil-lets feminine hygiene brand. Various absorbencies are available, in single type and mixed packs. All contain aloe to help neutralise odours, micro-gel beads and 'whisper' wrapping for discretion.
Prices: see C+D Monthly Pricelist
Lil-lets; tel: 0121 270 8100

Crisp new look

New packaging has been introduced across the Opticrom allergy eyedrop range. The design aims to give the brand a crisp, refreshed and contemporary look while keeping its reassuring familiarity, says manufacturer Sanofi Aventis.

Opticrom claims to be the market leader in the 'hayfever eyes' sector, with a share of more than 70 per cent (source: IMS November MAT 2007). Its active ingredient is sodium cromoglicate, which SA says works best when used regularly for allergic responses.

Supporting the brand is in-store activity, including a window display competition, with POS materials from Laser.

Product info:
Laser Healthcare
Tel: 01202 449700

Sustained campaign

Oralcare brand Sensodyne will be in the public eye this year thanks to a promotional spend of £8.5 million by manufacturer GSK.

Two TV campaigns are running, one for Sensodyne Pronamel, the other for Sensodyne Total Care F, on alternate weeks from now until October. There are two 30 second Pronamel creatives, each featuring company experts discussing the problem of acid erosion and how the product can provide protection.

For Total Care F, three consumer testimonial adverts are showing, telling viewers how the product gives relief from sensitive teeth.

Product info:
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637

Products advertised on TV next week

Berocca: All areas
Frontline Spot On: GMTV, five, Sat, West Country
Hedrin: GMTV, five, Sat
Rennie Dual Action: All areas
Seabond: All areas
Sensodyne Pronamel: Sat
Seven Seas JointCare & CLO: All areas
PharmaSite for next week: Iglü – windows, **Zantac** – in-store, **Zirtek** – dispensary
Pharmacy channel: Give it up!, Clearly Herbal

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Man of the

With Lord Darzi set to shake up the way that primary care services are delivered, **Jennifer Richardson** meets Andy Murdock, the man making the case for pharmacy

Five things you didn't know about Andy Murdock

1. **The first record he bought was the Beach Boys' Greatest Hits, closely followed by Deep Purple's Machine Head: "Now there's a clash of musical cultures if ever there was one. I still listen to Deep Purple's Machine Head."**
2. **His nickname at school was Joe, after the spectacle-sporting character in the 1960s TV series Joe 90.**
3. **Catherine Zeta Jones just pips Felicity Kendall to the post to make his dream date: "I think she's stunning... but she'd probably scare me to death!"**
4. **The most revolting thing he's ever eaten was a Romanian dish of spinach and runny egg: "It was very gelatinous. Vomit-inducing."**
5. **His guilty pleasure is buying gadgets: "I've just bought a brand new all-in-one printer and my wife said, 'What have you bought that for?' I just wanted to."**

A morning discussion with an England cricketing star about diabetes, followed by an afternoon chatting with MPs in the House of Commons about their blood pressure – it doesn't sound like a typical working day, does it?

But then, Andy Murdock doesn't have a typical working day. The pharmacy director of Lloydspharmacy, Mr Murdock is also the profession's only representative on the board of the most wide-ranging review of the NHS since its origin 60 years ago.

So his views on the future of pharmacy really count. And Mr Murdock is under no illusions about how important Lord Darzi's NHS Next Stage Review could be for the profession. "I think the next platform for pharmacy moving forward should be decided – can be decided – within this next timeframe," he says.

But, first up, he wants to dissipate the fears of those who worry he will use – or abuse – his position to push the agenda of the large multiples. A pharmacy reference group of representatives from community pharmacy, hospital pharmacy and PCTs are shaping his input into the review, and he has consulted with national pharmacy bodies including the Independent Pharmacy Federation.

And Mr Murdock thinks every pharmacist needs to be involved in making sure pharmacy's voice is heard at a local level. "I can't do it all myself," he points out.

Besides, Mr Murdock says, there is not so much discord around the profession's next steps. "I've tried to get views from a range of people and there's a good degree of commonality about where pharmacy should go," he says. "I'd be a bit more worried if we were all scattered off to all four corners of the earth, but I don't sense that."

Something pharmacists do appear to be largely united on is also the one thing most synonymous with the Darzi name: polyclinics. And they are united in mistrust. But, while Mr Murdock recognises the fears, he sees them as out of proportion. "Polyclinics will have a role but, like most things in life, they're not going to be the be all and end all. It's going to be a mixed economy," he says. "If we step up to the mark I think, because of pharmacy's presence in under-doctored areas, we can still provide great access."

Note the 'if'. Because Mr Murdock believes pharmacists can be guilty of not helping themselves. "We've got to get out there and become masters of our own destiny," he challenges. "We've got to stand up and be counted. Nobody's going to give it to us; we're going to have to fight.

"There's a lot at the moment to be fought for and a lot potentially to be secured for pharmacy but we've got to get off our backsides and do it, and I don't see a lot of people getting off their backsides."

Career timeline

1976-79
Studied pharmacy at Nottingham University

1979-80
Split pre-reg year at Royal London Hospital and Wellcome Foundation

1980-82
Worked as an industrial pharmacist at Wellcome Foundation

1982-93
Superintendent pharmacist of a two-pharmacy business in Somerset

1993-97
Management position at AAH follows employer's buyout by the wholesaler

1997-2004
Superintendent and pharmacy director at Lloydspharmacy

moment

Medicines use reviews are the "classic example", Mr Murdock says. "The gauntlet was thrown down but it's taken an age for that gauntlet to be picked up, and perhaps it hasn't been yet." It's all very well talking about taking on more clinical roles, but actions speak louder than words, he adds: "Pharmacy needs to decide what it wants."

"Why is only roughly half the pharmacy population delivering MURs?" Mr Murdock asks, immediately suggesting possible answers to his own question: perhaps they're being over-engineered; pharmacists are fearful of them; their introduction was insufficient; public relations exercises were too little, too late; the incentives aren't there.

So why has Lloyds put so much effort into them? "Because we believe in the contract. We believe in moving the profession forward."

And perhaps it is Mr Murdock's personal belief in this that explains why he exudes frustration at the speed of pharmacy's progress in some areas. "Nothing happens with a big bang in pharmacy. By and large, it tends to be evolutionary rather than revolutionary," he says. "I do think we have to speed up now, I really do." But it seems plausible that, coupled with his obvious enthusiasm for the profession, translating that frustration into proactive desire for change has got Mr Murdock where he is today.

For someone who says he fell into pharmacy by accident, becoming director at the UK's second largest multiple is a pretty steep trajectory. And although he misses using his clinical skills, Mr Murdock enjoys his work in service development and influencing government. "It's the variety that's the most interesting," he says and, even when pushed, cannot identify what he doesn't like about his job. "If someone had said to me in 1993 – when I was still operating as a pharmacist at the coalface, as it were – I'd be talking to politicians in the House of Commons, I'd have said they were mad," he laughs.

When talking strategy with the suits, Mr Murdock tries to reflect back to that time in the dispensary, to imagine how changes might impact on pharmacists' working days. "I think, OK, what might this feel like? Because you know how it works," he says.

And if he manages to combine that down-to-earth approach with his stratospheric ambition for the profession and convey them to Lord Darzi and team with his trademark enthusiasm, perhaps pharmacy could yet emerge from the NHS review on top.

2004-present
Relinquished superintendency to expand the Lloydspharmacy pharmacy director role


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How to be SPECIAL in five steps

Interested in becoming a pharmacist with a special interest? Beth Taylor takes you through five steps to success

What does the term pharmacist with special interests (PhwSI) mean to you? Is this a role you assume is more relevant for others, or do you perhaps have personal ambition to become a PhwSI at some point in your career?

If you are an experienced pharmacist practising in England, and see opportunities for developing your competences beyond your core role, then this might be something to aim for.

First and foremost, you will find that this role is a partnership. You as the practitioner will be required to develop your specific specialist skills (usually alongside colleagues) and ultimately provide evidence of these to an independent panel of accreditors. In tandem, your local NHS commissioners must assess exactly what specialist services delivered by PhwSIs are needed locally, develop the care pathway, and then commission specialist care in line with this.

Both partners must work in parallel: if practitioners with the right skills are not available then commissioners will fail to deliver a new service; equally, no pharmacists will be able to progress to PhwSI accreditation unless their services are being commissioned through the NHS.

Step 1

So if the PhwSI role interests you, what's the first step? Read the national PhwSI framework, and have a look at the PhwSI section of the NHS Primary Care Contracting website (see box on p36), which has a wide range of tools and resources to support pharmacists working towards PhwSI accreditation.

The best place to start is probably the updated PhwSI personal development tool, which guides the practitioner through several defined steps, identifies key questions that need to be considered at each step, and signposts the resources available.

Whether you work in a multiple or independent community pharmacy, the challenges you will meet during this development process will be similar. Any locum pharmacist would need to demonstrate that there would be adequate return for the NHS from their training and development, reflecting the relatively advanced level of competence that this role requires.

Step 2

You will need to do some background reading about the PhwSI (and linked GPwSI) role so you have a good understanding of how this can be developed and contribute to the shift of care closer to home. There are sometimes misconceptions, for instance that the PhwSI is a 'consultant in the community'. This is not so as PhwSIs are both generalist and specialists, but they should be working closely with and may be supervised by both medical consultants and consultant pharmacists in the same specialty. The case studies and presentations on the PCC website by existing practitioners working in similar roles to PhwSIs will help to illustrate the potential that the model offers.

Step 3

If you reach step 3 – support from commissioners – then it's time to look at the outline PhwSI portfolio, which gives a structure within which you can begin to collate all the evidence which may be required during the accreditation process.

You should also read the Department of Health's accreditation guidance so that you have a clear picture of this quite demanding process. This is necessary as in order to protect patients and the public, those practitioners who provide specialist care beyond their normal role must be able to demonstrate that they are competent to do so.

Perhaps you already have some experience of providing more specialist care, such as in substance misuse or anticoagulation services? In this case, you should find that you can include existing evidence such as audits, formal training and supervised practice in your portfolio.

Step 4

At this stage you will also need to look at the service specification in detail and talk to commissioners to confirm the competences that they will be seeking for the role being commissioned. The PhwSI model is designed to be flexible locally so the role could vary across different PCTs. It is likely that other pharmacists will also be considering this path and it may be very helpful to seek support from colleagues and also from PCT pharmacists.

The commissioning guidance recognises that PCTs or other commissioners may need to 'pump prime' training and development for new roles well ahead of the planned starting date, and a long lead time may be required, eg to complete training as a supplementary or independent prescriber.

PhwSI personal development tool

www.primarycarecontracting.nhs.uk/uploads/pwsis/december2007/phwsipersonaldevelopmenttoolversion2dec07final.pdf

Step 1
What is a pharmacist with a special interest, and how do I find out more about this opportunity?

Step 2
I think that this model has potential for me and I'm definitely interested – what should I do next?

Step 3
Commissioners have indicated that some local service(s) will be commissioned through PhwSIs and I would now like to go forward for accreditation – how do I do this?

Step 4
I've been successfully accredited as a PhwSI, how can specific specialist pharmacy services now be commissioned?

Step 5
What do I need to think about once services are up and running?

Key types of evidence that may be required for PhwSI accreditation:

- **PCT Application form (check format with your PCT)**
- **Summary of evidence to demonstrate relevant competencies, based on generic PhwSI competency framework**
- **Evidence of competence in core role**
- **Evidence of formal learning**
- **Evidence of supervised practice**
- **Reference from an independent clinician to confirm the applicant's competence in the new role**

Step 5

The outline portfolio and the generic PhwSI competency framework both give examples of the types of evidence that may be included in your portfolio. A relatively new element will be evidence of supervised practice, perhaps assessed through some of the tools seen on the website such as Mini-CEX or Case-based discussion www.primarycarecontracting.nhs.uk/246.php. Pharmacists who have completed diploma courses may already be familiar with this approach but they are a fundamentally important part of any PhwSI training and preparation.

There are opportunities for pharmacists to contribute at all levels to specialist care, so if the PhwSI level proves not to be for you, you could still be able to use any additional skills you have gained in your normal role. If you are able to become an accredited PhwSI during 2008, you will one of the first pharmacists able to use their clinical expertise in this way and will truly have helped to take the profession forward.

Beth Taylor is national development lead, Pharmacists with Special Interests, NHS Primary Care Contracting

What's available on the Primary Care Contracting website?

PhwSIs

- The National Framework for PhwSIs
- Presentations and learning from workshops in October 2007 for potential early adopters
- PhwSI briefings
- Link to national publications on commissioning and accreditation of practitioners with special interests (PwSIs)

All available at www.primarycarecontracting.nhs.uk/119.php

Supporting PhwSI accreditation

- PhwSI generic competency framework – this can help to differentiate between practitioner and PhwSI-level competency, and can be used alongside any PwSI speciality guidance
- Personal development tool
- Outline PhwSI portfolio and assessment tools for supervised practice
- Link to speciality-specific guidance (as it becomes available later in 2008)

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If you think you have what it takes, send your CV and a covering letter by email to Gary Paragpuri MRPharmS, C+D Editor, at **gparagpuri@cmpmedica.com** or post to **Chemist+Druggist, CMP Medica, Riverbank House, Angel Lane, Tonbridge, Kent TN9 1SE.** **Closing date: April 25, 2008**

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The conference diary...

... Cape Town was, apparently, a safe haven for sailors in days gone by. Hence it was an appropriate place to be for the 2008 AAH Convention, given the rough seas pharmacy is currently sailing on...

This was AAH managing director Mark James' introduction to the business sessions at last week's convention in South Africa, but as any reader of the sports pages knows, the action off the pitch can be just as entertaining... with most people arriving on overnight flights from the UK, the first day was about settling in and catching up with old friends. Some, like Makinder Suri, who confessed to this being her 20th convention, had rather more catching up to do than first timers Paul and Jane Durston, who run the only pharmacy on the Channel Island of Alderney.

Set halfway between Table Mountain and the waterfront in Cape Town, the Mount Nelson Hotel offered a welcome retreat. Along with others, La Babybel (Claire Conroy) and Le Grand Fromage (Rob Yateman) topped up the suntan and mulled over whether the trade knew them as J&J or McNeil Products. But the action (if there was any on Day 1) was in the gym, where the AAH management team was demonstrating fitness with purpose. Mark James was pumping up some already pretty impressive biceps, while Leon Rudd and David Tattersall sweated buckets on the rowing machine. The day rounded off with a poolside reception. Phil Byrne (BR Pharmaceuticals) revealed his soft centre when he was exposed as the sponsor of the pillow chocolates, and delegates spent the first of two nights being entertained by terrifying chantreuse – terrifying to all but Terry Prudhoe (Aspar), that is.

Down to the serious stuff on Day 2. An early encounter was between Northern Ireland's Sheelin McKeagney and an unexpected face at the convention – colleague Sheelagh Hillan. She just happened to be holidaying down the road, so decided to drop into the business sessions – after popping in to make sure Sheelin was eating a proper breakfast.

Among the pearls of wisdom you won't see in the conference report on p12 (and at www.chemistanddruggist.co.uk/news) is the view from primary care czar Dr Colin-Thomé that "practice-based commissioning is having its second death". He is praying for another resurrection though, so don't write it off the policy agenda yet. Reckitt's Trevor Gore announced a range extension for Lemsip – a suppository with a novel mode of action in that it makes you too scared to sneeze.

There is no doubt Kim Innes (Teva) knows how to party. Madame Zingara's Evening of Intrigue was a bohemian dining experience, involving an 'art deco' circus tent, one horny goat, an impossibly elastic Japanese gymnast, two strong men, three trapeze artistes, four large African ladies (AAH's Gary Lunt was in love by this point), and a cast of assorted waiters. Toss in a dash of fancy dress – Annette D'Abreo (Ceuta) and Gordon Farquhar (Co-op Pharmacy) looked angelic in their pink fairy wings – and let the show commence.

Then there was sports day. Polo certainly isn't as easy as the pros make it look. For Day Lewis CEO Kirit Patel it was a challenge to be overcome (a bit like category M). After a brief introduction, he was in the saddle, along with eight other aspiring players, for his first chukka. The betting on the touchline was that he would be the first to be unhorsed, but the superglue worked and he stuck in the saddle.

If there's a game of rugby to be had, you'll find Mark Griffiths from Nantyglo RFC (he does something with the Cambrian Alliance in his spare time). With the Hurricanes in town to play the Stormers in the Super 14, where else would the Welsh crowd be?

However, the convention's Sports Award goes to Carol Northwood for her ascent of Table Mountain. She was marched up to the top by husband Harvey ... and marched back down again. The plan had been to descend by cable car, but as the summit got closer the cloud closed in, the wind got up and the cable car stopped running... so what started out as a two-hour hike turned into a five-hour marathon.

It seemed nothing was too much for the convention organisers – even lighting up Table Mountain. You could not help but notice the illuminations at the Gala Dinner. And, yes, with government permission, for the first time in three months the peak was lit up.

Time for home then, but not for everyone. The Actavis team owned up to their own special extension. By one of those strange coincidences the company just happens to be having its sales conference down at a Waterfront hotel this week. Don't try calling the office...

From top to bottom: AAH's Gary Lunt and a horny David Tattersall settle in at Madame Zingara's; Sheelagh Hillan – not listed among the pharmacist delegates; Carol 'ooooh my legs hurt' Northwood and husband Harvey at the Gala Dinner after their summit attempt; Steven Lo getting into the swing at the polo

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References: 1. Bohadana A, et al. Arch Intern Med 2000; 160:3128-3134.

Date of preparation: March 2008

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